

## ***In the Senate of the United States,***

*October 14, 1999.*

*Resolved*, That the bill from the House of Representatives (H.R. 2990) entitled “An Act to amend the Internal Revenue Code of 1986 to allow individuals greater access to health insurance through a health care tax deduction, a long-term care deduction, and other health-related tax incentives, to amend the Employee Retirement Income Security Act of 1974 to provide access to and choice in health care through association health plans, to amend the Public Health Service Act to create new pooling opportunities for small employers to obtain greater access to health coverage through HealthMarts; to amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; and for other purposes.”, do pass with the following

### **AMENDMENT:**

Strike out all after the enacting clause and insert:

1 ***SECTION 1. SHORT TITLE; TABLE OF CONTENTS.***

2       (a) *SHORT TITLE*.—*This Act may be cited as the “Pa-*  
3 *tients’ Bill of Rights Plus Act”.*

4       (b) *TABLE OF CONTENTS*.—*The table of contents for*  
5 *this Act is as follows:*

*Sec. 1. Short title; table of contents.*

## ***TITLE I—PATIENTS’ BILL OF RIGHTS***

### ***Subtitle A—Right to Advice and Care***

*Sec. 101. Patient right to medical advice and care.*

#### ***“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE***

*“Sec. 721. Patient access to emergency medical care.*

*“Sec. 722. Offering of choice of coverage options.*

*“Sec. 723. Patient access to obstetric and gynecological care.*

*“Sec. 724. Patient access to pediatric care.*

*“Sec. 725. Timely access to specialists.*

*“Sec. 726. Continuity of care.*

*“Sec. 727. Protection of patient-provider communications.*

*“Sec. 728. Patient’s right to prescription drugs.*

*“Sec. 729. Self-payment for behavioral health care services.*

*“Sec. 730. Coverage for individuals participating in approved cancer clinical trials.*

*“Sec. 730A. Prohibiting discrimination against providers.*

*“Sec. 730B. Generally applicable provision.”.*

*Sec. 102. Conforming amendment to the Internal Revenue Code of 1986.*

#### ***“SUBCHAPTER C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE***

*“Sec. 9821. Patient access to emergency medical care.*

*“Sec. 9822. Offering of choice of coverage options.*

*“Sec. 9823. Patient access to obstetric and gynecological care.*

*“Sec. 9824. Patient access to pediatric care.*

*“Sec. 9825. Timely access to specialists.*

*“Sec. 9826. Continuity of care.*

*“Sec. 9827. Protection of patient-provider communications.*

*“Sec. 9828. Patient’s right to prescription drugs.*

*“Sec. 9829. Self-payment for behavioral health care services.*

*“Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.*

*“Sec. 9830A. Prohibiting discrimination against providers.*

*“Sec. 9830B. Generally applicable provision.”.*

*Sec. 103. Effective date and related rules.*

### ***Subtitle B—Right to Information About Plans and Providers***

*Sec. 111. Information about plans.*

*Sec. 112. Information about providers.*

### ***Subtitle C—Right to Hold Health Plans Accountable***

*Sec. 121. Amendment to Employee Retirement Income Security Act of 1974.*

## ***TITLE II—WOMEN’S HEALTH AND CANCER RIGHTS***

*Sec. 201. Women’s health and cancer rights.*

## ***TITLE III—GENETIC INFORMATION AND SERVICES***

*Sec. 301. Short title.*

*Sec. 302. Amendments to Employee Retirement Income Security Act of 1974.*

*Sec. 303. Amendments to the Public Health Service Act.*

*Sec. 304. Amendments to the Internal Revenue Code of 1986.*

#### *TITLE IV—HEALTHCARE RESEARCH AND QUALITY*

*Sec. 401. Short title.*

*Sec. 402. Amendment to the Public Health Service Act.*

#### *“TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY*

##### *“PART A—ESTABLISHMENT AND GENERAL DUTIES*

*“Sec. 901. Mission and duties.*

*“Sec. 902. General authorities.*

##### *“PART B—HEALTHCARE IMPROVEMENT RESEARCH*

*“Sec. 911. Healthcare outcome improvement research.*

*“Sec. 912. Private-public partnerships to improve organization and delivery.*

*“Sec. 913. Information on quality and cost of care.*

*“Sec. 914. Information systems for healthcare improvement.*

*“Sec. 915. Research supporting primary care and access in underserved areas.*

*“Sec. 916. Clinical practice and technology innovation.*

*“Sec. 917. Coordination of Federal government quality improvement efforts.*

##### *“PART C—GENERAL PROVISIONS*

*“Sec. 921. Advisory Council for Healthcare Research and Quality.*

*“Sec. 922. Peer review with respect to grants and contracts.*

*“Sec. 923. Certain provisions with respect to development, collection, and dissemination of data.*

*“Sec. 924. Dissemination of information.*

*“Sec. 925. Additional provisions with respect to grants and contracts.*

*“Sec. 926. Certain administrative authorities.*

*“Sec. 927. Funding.*

*“Sec. 928. Definitions.”.*

*Sec. 403. References.*

#### *TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE*

*Sec. 501. Full deduction of health insurance costs for self-employed individuals.*

*Sec. 502. Full availability of medical savings accounts.*

*Sec. 503. Permitting contribution towards medical savings account through Federal employees health benefits program (FEHBP).*

*Sec. 504. Carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts.*

#### *TITLE VI—PROVISIONS RELATING TO LONG-TERM CARE INSURANCE*

*Sec. 601. Inclusion of qualified long-term care insurance contracts in cafeteria plans, flexible spending arrangements, and health flexible spending accounts.*

*Sec. 602. Deduction for premiums for long-term care insurance.*

*Sec. 603. Study of long-term care needs in the 21st century.*

*TITLE VII—INDIVIDUAL RETIREMENT PLANS*

*Sec. 701. Modification of income limits on contributions and rollovers to Roth IRAs.*

*TITLE VIII—REVENUE PROVISIONS*

*Sec. 801. Modification to foreign tax credit carryback and carryover periods.*

*Sec. 802. Limitation on use of non-accrual experience method of accounting.*

*Sec. 803. Returns relating to cancellations of indebtedness by organizations lending money.*

*Sec. 804. Extension of Internal Revenue Service user fees.*

*Sec. 805. Property subject to a liability treated in same manner as assumption of liability.*

*Sec. 806. Charitable split-dollar life insurance, annuity, and endowment contracts.*

*Sec. 807. Transfer of excess defined benefit plan assets for retiree health benefits.*

*Sec. 808. Limitations on welfare benefit funds of 10 or more employer plans.*

*Sec. 809. Modification of installment method and repeal of installment method for accrual method taxpayers.*

*Sec. 810. Inclusion of certain vaccines against streptococcus pneumoniae to list of taxable vaccines.*

*TITLE IX—MISCELLANEOUS PROVISIONS*

*Sec. 901. Medicare competitive pricing demonstration project.*

1       ***TITLE I—PATIENTS’ BILL OF***  
2                       ***RIGHTS***  
3       ***Subtitle A—Right to Advice and***  
4                       ***Care***

5   ***SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.***

6       (a) *IN GENERAL.*—Part 7 of subtitle B of title I of  
7   the *Employee Retirement Income Security Act of 1974* (29  
8   *U.S.C. 1181 et seq.*) is amended—

9               (1) *by redesignating subpart C as subpart D;*

10       *and*

11       (2) *by inserting after subpart B the following:*

1     **“Subpart C—Patient Right to Medical Advice and**  
2                                     **Care**

3     **“SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL**  
4                                     **CARE.**

5             “(a) *COVERAGE OF EMERGENCY CARE.—*

6                     “(1) *IN GENERAL.—To the extent that the group*  
7             *health plan (other than a fully insured group health*  
8             *plan) provides coverage for benefits consisting of*  
9             *emergency medical care (as defined in subsection (c))*  
10            *or emergency ambulance services, except for items or*  
11            *services specifically excluded—*

12                    “(A) *the plan shall provide coverage for*  
13            *benefits, without requiring preauthorization, for*  
14            *emergency medical screening examinations or*  
15            *emergency ambulance services, to the extent that*  
16            *a prudent layperson, who possesses an average*  
17            *knowledge of health and medicine, would deter-*  
18            *mine such examinations or emergency ambu-*  
19            *lance services to be necessary to determine wheth-*  
20            *er emergency medical care (as so defined) is nec-*  
21            *essary; and*

22                    “(B) *the plan shall provide coverage for*  
23            *benefits, without requiring preauthorization, for*  
24            *additional emergency medical care to stabilize*  
25            *an emergency medical condition following an*  
26            *emergency medical screening examination (if de-*

1        *terminated necessary under subparagraph (A)),*  
 2        *pursuant to the definition of stabilize under sec-*  
 3        *tion 1867(e)(3) of the Social Security Act (42*  
 4        *U.S.C. 1395dd(e)(3)).*

5        *“(2) REIMBURSEMENT FOR CARE TO MAINTAIN*  
 6        *MEDICAL STABILITY.—*

7                *“(A) IN GENERAL.—In the case of services*  
 8        *provided to a participant or beneficiary by a*  
 9        *nonparticipating provider in order to maintain*  
 10        *the medical stability of the participant or bene-*  
 11        *ficiary, the group health plan involved shall pro-*  
 12        *vide for reimbursement with respect to such serv-*  
 13        *ices if—*

14                *“(i) coverage for services of the type*  
 15        *furnished is available under the group*  
 16        *health plan;*

17                *“(ii) the services were provided for care*  
 18        *related to an emergency medical condition*  
 19        *and in an emergency department in order*  
 20        *to maintain the medical stability of the*  
 21        *participant or beneficiary; and*

22                *“(iii) the nonparticipating provider*  
 23        *contacted the plan regarding approval for*  
 24        *such services.*

1           “(B) *FAILURE TO RESPOND.*—If a group  
 2           health plan fails to respond within 1 hours of  
 3           being contacted in accordance with subpara-  
 4           graph (A)(iii), then the plan shall be liable for  
 5           the cost of services provided by the nonpartici-  
 6           pating provider in order to maintain the sta-  
 7           bility of the participant or beneficiary.

8           “(C) *LIMITATION.*—The liability of a group  
 9           health plan to provide reimbursement under sub-  
 10          paragraph (A) shall terminate when the plan  
 11          has contacted the nonparticipating provider to  
 12          arrange for discharge or transfer.

13          “(D) *LIABILITY OF PARTICIPANT.*—A par-  
 14          ticipant or beneficiary shall not be liable for the  
 15          costs of services to which subparagraph (A) in an  
 16          amount that exceeds the amount of liability that  
 17          would be incurred if the services were provided  
 18          by a participating health care provider with  
 19          prior authorization by the plan.

20          “(b) *IN-NETWORK UNIFORM COSTS-SHARING AND*  
 21          *OUT-OF-NETWORK CARE.*—

22               “(1) *IN-NETWORK UNIFORM COST-SHARING.*—  
 23          Nothing in this section shall be construed as pre-  
 24          venting a group health plan (other than a fully in-  
 25          sured group health plan) from imposing any form of

1     *cost-sharing applicable to any participant or bene-*  
2     *ficiary (including coinsurance, copayments,*  
3     *deductibles, and any other charges) in relation to cov-*  
4     *erage for benefits described in subsection (a), if such*  
5     *form of cost-sharing is uniformly applied under such*  
6     *plan, with respect to similarly situated participants*  
7     *and beneficiaries, to all benefits consisting of emer-*  
8     *gency medical care (as defined in subsection (c)) pro-*  
9     *vided to such similarly situated participants and*  
10    *beneficiaries under the plan, and such cost-sharing is*  
11    *disclosed in accordance with section 714.*

12           “(2) *OUT-OF-NETWORK CARE.*—*If a group health*  
13    *plan (other than a fully insured group health plan)*  
14    *provides any benefits with respect to emergency med-*  
15    *ical care (as defined in subsection (c)), the plan shall*  
16    *cover emergency medical care under the plan in a*  
17    *manner so that, if such care is provided to a partici-*  
18    *part or beneficiary by a nonparticipating health care*  
19    *provider, the participant or beneficiary is not liable*  
20    *for amounts that exceed any form of cost-sharing (in-*  
21    *cluding co-insurance, co-payments, deductibles, and*  
22    *any other charges) that would be incurred if the serv-*  
23    *ices were provided by a participating provider.*

24           “(c) *DEFINITION OF EMERGENCY MEDICAL CARE.*—*In*  
25    *this section:*



1           “(1) *IN GENERAL.*—*The term ‘emergency medical*  
2           *care’ means, with respect to a participant or bene-*  
3           *ficiary under a group health plan (other than a fully*  
4           *insured group health plan), covered inpatient and*  
5           *outpatient services that—*

6                     *“(A) are furnished by any provider, includ-*  
7                     *ing a nonparticipating provider, that is quali-*  
8                     *fied to furnish such services; and*

9                     *“(B) are needed to evaluate or stabilize (as*  
10                    *such term is defined in section 1867(e)(3) of the*  
11                    *Social Security Act (42 U.S.C. 1395dd)(e)(3))*  
12                    *an emergency medical condition (as defined in*  
13                    *paragraph (2)).*

14           “(2) *EMERGENCY MEDICAL CONDITION.*—*The*  
15           *term ‘emergency medical condition’ means a medical*  
16           *condition manifesting itself by acute symptoms of suf-*  
17           *ficient severity (including severe pain) such that a*  
18           *prudent layperson, who possesses an average knowl-*  
19           *edge of health and medicine, could reasonably expect*  
20           *the absence of immediate medical attention to result*  
21           *in—*

22                     *“(A) placing the health of the participant or*  
23                     *beneficiary (or, with respect to a pregnant*  
24                     *woman, the health of the woman or her unborn*  
25                     *child) in serious jeopardy,*

1                   “(B) *serious impairment to bodily func-*  
 2                   *tions, or*

3                   “(C) *serious dysfunction of any bodily*  
 4                   *organ or part.*

5   **“SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

6           “(a) *REQUIREMENT.—*

7                   “(1) *OFFERING OF POINT-OF-SERVICE COVERAGE*  
 8                   *OPTION.—Except as provided in paragraph (2), if a*  
 9                   *group health plan (other than a fully insured group*  
 10                   *health plan) provides coverage for benefits only*  
 11                   *through a defined set of participating health care pro-*  
 12                   *fessionals, the plan shall offer the participant the op-*  
 13                   *tion to purchase point-of-service coverage (as defined*  
 14                   *in subsection (b)) for all such benefits for which cov-*  
 15                   *erage is otherwise so limited. Such option shall be*  
 16                   *made available to the participant at the time of en-*  
 17                   *rollment under the plan and at such other times as*  
 18                   *the plan offers the participant a choice of coverage op-*  
 19                   *tions.*

20                   “(2) *EXCEPTION IN CASE OF LACK OF AVAIL-*  
 21                   *ABILITY.—Paragraph (1) shall not apply with respect*  
 22                   *to a group health plan (other than a fully insured*  
 23                   *group health plan) if care relating to the point-of-*  
 24                   *service coverage would not be available and accessible*  
 25                   *to the participant with reasonable promptness (con-*

1       sistent with section 1301(b)(4) of the Public Health  
2       Service Act (42 U.S.C. 300e(b)(4))).

3       “(b) *POINT-OF-SERVICE COVERAGE DEFINED.*—In  
4       this section, the term ‘point-of-service coverage’ means, with  
5       respect to benefits covered under a group health plan (other  
6       than a fully insured group health plan), coverage of such  
7       benefits when provided by a nonparticipating health care  
8       professional.

9       “(c) *SMALL EMPLOYER EXEMPTION.*—

10           “(1) *IN GENERAL.*—This section shall not apply  
11       to any group health plan (other than a fully insured  
12       group health plan) of a small employer.

13           “(2) *SMALL EMPLOYER.*—For purposes of para-  
14       graph (1), the term ‘small employer’ means, in con-  
15       nection with a group health plan (other than a fully  
16       insured group health plan) with respect to a calendar  
17       year and a plan year, an employer who employed an  
18       average of at least 2 but not more than 50 employees  
19       on business days during the preceding calendar year  
20       and who employs at least 2 employees on the first day  
21       of the plan year. For purposes of this paragraph, the  
22       provisions of subparagraph (C) of section 712(c)(1)  
23       shall apply in determining employer size.

24       “(d) *RULE OF CONSTRUCTION.*—Nothing in this sec-  
25       tion shall be construed—

1           “(1) as requiring coverage for benefits for a par-  
2           ticular type of health care professional;

3           “(2) as requiring an employer to pay any costs  
4           as a result of this section or to make equal contribu-  
5           tions with respect to different health coverage options;

6           “(3) as preventing a group health plan (other  
7           than a fully insured group health plan) from impos-  
8           ing higher premiums or cost-sharing on a participant  
9           for the exercise of a point-of-service coverage option;  
10          or

11          “(4) to require that a group health plan (other  
12          than a fully insured group health plan) include cov-  
13          erage of health care professionals that the plan ex-  
14          cludes because of fraud, quality of care, or other simi-  
15          lar reasons with respect to such professionals.

16   **“SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**  
17                           **LOGICAL CARE.**

18          “(a) *GENERAL RIGHTS.*—

19               “(1) *WAIVER OF PLAN REFERRAL REQUIRE-*  
20               *MENT.*—If a group health plan described in subsection  
21               (b) requires a referral to obtain coverage for specialty  
22               care, the plan shall waive the referral requirement in  
23               the case of a female participant or beneficiary who  
24               seeks coverage for obstetrical care and related follow-

1       up obstetrical care or routine gynecological care (such  
2       as preventive gynecological care).

3               “(2) *RELATED ROUTINE CARE*.—With respect to  
4       a participant or beneficiary described in paragraph  
5       (1), a group health plan described in subsection (b)  
6       shall treat the ordering of other routine care that is  
7       related to routine gynecologic care, by a physician  
8       who specializes in obstetrics and gynecology as the  
9       authorization of the primary care provider for such  
10      other care.

11             “(b) *APPLICATION OF SECTION*.—A group health plan  
12      described in this subsection is a group health plan (other  
13      than a fully insured group health plan), that—

14               “(1) provides coverage for obstetric care (such as  
15      pregnancy-related services) or routine gynecologic  
16      care (such as preventive women’s health examina-  
17      tions); and

18               “(2) requires the designation by a participant or  
19      beneficiary of a participating primary care provider  
20      who is not a physician who specializes in obstetrics  
21      or gynecology.

22             “(c) *RULES OF CONSTRUCTION*.—Nothing in this sec-  
23      tion shall be construed—

24               “(1) as waiving any coverage requirement relat-  
25      ing to medical necessity or appropriateness with re-

1       *spect to the coverage of obstetric or gynecologic care*  
 2       *described in subsection (a);*

3               *“(2) to preclude the plan from requiring that the*  
 4       *physician who specializes in obstetrics or gynecology*  
 5       *notify the designated primary care provider or the*  
 6       *plan of treatment decisions;*

7               *“(3) to preclude a group health plan from allow-*  
 8       *ing health care professionals other than physicians to*  
 9       *provide routine obstetric or routine gynecologic care;*  
 10       *or*

11               *“(4) to preclude a group health plan from per-*  
 12       *mitting a physician who specializes in obstetrics and*  
 13       *gynecology from being a primary care provider under*  
 14       *the plan.*

15       **“SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.**

16               *“(a) IN GENERAL.—In the case of a group health plan*  
 17       *(other than a fully insured group health plan) that provides*  
 18       *coverage for routine pediatric care and that requires the*  
 19       *designation by a participant or beneficiary of a partici-*  
 20       *pating primary care provider, if the designated primary*  
 21       *care provider is not a physician who specializes in*  
 22       *pediatrics—*

23               *“(1) the plan may not require authorization or*  
 24       *referral by the primary care provider in order for a*

1        *participant or beneficiary to obtain coverage for rou-*  
 2        *tine pediatric care; and*

3                *“(2) the plan shall treat the ordering of other*  
 4        *routine care related to routine pediatric care by such*  
 5        *a specialist as having been authorized by the des-*  
 6        *ignated primary care provider.*

7        *“(b) RULES OF CONSTRUCTION.—Nothing in sub-*  
 8        *section (a) shall be construed—*

9                *“(1) as waiving any coverage requirement relat-*  
 10        *ing to medical necessity or appropriateness with re-*  
 11        *spect to the coverage of any pediatric care provided*  
 12        *to, or ordered for, a participant or beneficiary;*

13                *“(2) to preclude a group health plan from re-*  
 14        *quiring that a specialist described in subsection (a)*  
 15        *notify the designated primary care provider or the*  
 16        *plan of treatment decisions; or*

17                *“(3) to preclude a group health plan from allow-*  
 18        *ing health care professionals other than physicians to*  
 19        *provide routine pediatric care.*

20        **“SEC. 725. TIMELY ACCESS TO SPECIALISTS.**

21                *“(a) TIMELY ACCESS.—*

22                *“(1) IN GENERAL.—A group health plan (other*  
 23        *than a fully insured group health plan) shall ensure*  
 24        *that participants and beneficiaries have timely, in*  
 25        *accordance with the medical exigencies of the case, ac-*

1      *cess to primary and specialty health care profes-*  
 2      *sionals who are appropriate to the condition of the*  
 3      *participant or beneficiary, when such care is covered*  
 4      *under the plan. Such access may be provided through*  
 5      *contractual arrangements with specialized providers*  
 6      *outside of the network of the plan.*

7           “(2) *RULE OF CONSTRUCTION.*—*Nothing in*  
 8      *paragraph (1) shall be construed—*

9           “(A) *to require the coverage under a group*  
 10      *health plan of particular benefits or services or*  
 11      *to prohibit a plan from including providers only*  
 12      *to the extent necessary to meet the needs of the*  
 13      *plan’s participants or beneficiaries or from es-*  
 14      *tablishing any measure designed to maintain*  
 15      *quality and control costs consistent with the re-*  
 16      *sponsibilities of the plan; or*

17          “(B) *to override any State licensure or*  
 18      *scope-of-practice law.*

19      “(b) *TREATMENT PLANS.*—

20          “(1) *IN GENERAL.*—*Nothing in this section shall*  
 21      *be construed to prohibit a group health plan (other*  
 22      *than a fully insured group health plan) from requir-*  
 23      *ing that specialty care be provided pursuant to a*  
 24      *treatment plan so long as the treatment plan is—*



1           “(A) developed by the specialist, in con-  
2           sultation with the case manager or primary care  
3           provider, and the participant or beneficiary;

4           “(B) approved by the plan in a timely  
5           manner in accordance with the medical exigen-  
6           cies of the case; and

7           “(C) in accordance with the applicable  
8           quality assurance and utilization review stand-  
9           ards of the plan.

10          “(2) NOTIFICATION.—Nothing in paragraph (1)  
11          shall be construed as prohibiting a plan from requir-  
12          ing the specialist to provide the case manager or pri-  
13          mary care provider with regular updates on the spe-  
14          cialty care provided, as well as all other necessary  
15          medical information.

16          “(c) REFERRALS.—Nothing in this section shall be  
17          construed to prohibit a plan from requiring an authoriza-  
18          tion by the case manager or primary care provider of the  
19          participant or beneficiary in order to obtain coverage for  
20          specialty services so long as such authorization is for an  
21          adequate number of referrals.

22          “(d) SPECIALTY CARE DEFINED.—For purposes of this  
23          subsection, the term ‘specialty care’ means, with respect to  
24          a condition, care and treatment provided by a health care  
25          practitioner, facility, or center (such as a center of excel-

1 lence) that has adequate expertise (including age-appro-  
 2 priate expertise) through appropriate training and experi-  
 3 ence.

4 **“SEC. 726. CONTINUITY OF CARE.**

5 “(a) *IN GENERAL.*—

6 “(1) *TERMINATION OF PROVIDER.*—If a contract  
 7 between a group health plan (other than a fully in-  
 8 sured group health plan) and a health care provider  
 9 is terminated (as defined in paragraph (2)), or bene-  
 10 fits or coverage provided by a health care provider are  
 11 terminated because of a change in the terms of pro-  
 12 vider participation in such group health plan, and  
 13 an individual who is a participant or beneficiary in  
 14 the plan is undergoing a course of treatment from the  
 15 provider at the time of such termination, the plan  
 16 shall—

17 “(A) notify the individual on a timely basis  
 18 of such termination;

19 “(B) provide the individual with an oppor-  
 20 tunity to notify the plan of a need for transi-  
 21 tional care; and

22 “(C) in the case of termination described in  
 23 paragraph (2), (3), or (4) of subsection (b), and  
 24 subject to subsection (c), permit the individual to  
 25 continue or be covered with respect to the course

1       *of treatment with the provider’s consent during*  
 2       *a transitional period (as provided under sub-*  
 3       *section (b)).*

4       “(2) *TERMINATED.*—*In this section, the term*  
 5       *‘terminated’ includes, with respect to a contract, the*  
 6       *expiration or nonrenewal of the contract by the group*  
 7       *health plan, but does not include a termination of the*  
 8       *contract by the plan for failure to meet applicable*  
 9       *quality standards or for fraud.*

10       “(3) *CONTRACTS.*—*For purposes of this section,*  
 11       *the term ‘contract between a group health plan (other*  
 12       *than a fully insured group health plan) and a health*  
 13       *care provider’ shall include a contract between such*  
 14       *a plan and an organized network of providers.*

15       “(b) *TRANSITIONAL PERIOD.*—

16       “(1) *GENERAL RULE.*—*Except as provided in*  
 17       *paragraph (3), the transitional period under this sub-*  
 18       *section shall permit the participant or beneficiary to*  
 19       *extend the coverage involved for up to 90 days from*  
 20       *the date of the notice described in subsection (a)(1)(A)*  
 21       *of the provider’s termination.*

22       “(2) *INSTITUTIONAL CARE.*—*Subject to para-*  
 23       *graph (1), the transitional period under this sub-*  
 24       *section for institutional or inpatient care from a pro-*  
 25       *vider shall extend until the discharge or termination*

1       of the period of institutionalization and also shall in-  
 2       clude institutional care provided within a reasonable  
 3       time of the date of termination of the provider status  
 4       if the care was scheduled before the date of the an-  
 5       nouncement of the termination of the provider status  
 6       under subsection (a)(1)(A) or if the individual on  
 7       such date was on an established waiting list or other-  
 8       wise scheduled to have such care.

9               “(3) *PREGNANCY.*—Notwithstanding paragraph  
 10       (1), if—

11               “(A) a participant or beneficiary has en-  
 12       tered the second trimester of pregnancy at the  
 13       time of a provider’s termination of participa-  
 14       tion; and

15               “(B) the provider was treating the preg-  
 16       nancy before the date of the termination;  
 17       the transitional period under this subsection with re-  
 18       spect to provider’s treatment of the pregnancy shall  
 19       extend through the provision of post-partum care di-  
 20       rectly related to the delivery.

21               “(4) *TERMINAL ILLNESS.*—Notwithstanding  
 22       paragraph (1), if—

23               “(A) a participant or beneficiary was deter-  
 24       mined to be terminally ill (as determined under  
 25       section 1861(dd)(3)(A) of the Social Security

1           *Act) prior to a provider’s termination of partici-*  
2           *pation; and*

3           *“(B) the provider was treating the terminal*  
4           *illness before the date of termination;*

5           *the transitional period under this subsection shall be*  
6           *for care directly related to the treatment of the ter-*  
7           *минаl illness and shall extend for the remainder of*  
8           *the individual’s life for such care.*

9           *“(c) PERMISSIBLE TERMS AND CONDITIONS.—A group*  
10          *health plan (other than a fully insured group health plan)*  
11          *may condition coverage of continued treatment by a pro-*  
12          *vider under subsection (a)(1)(C) upon the provider agreeing*  
13          *to the following terms and conditions:*

14                *“(1) The provider agrees to accept reimburse-*  
15                *ment from the plan and individual involved (with re-*  
16                *spect to cost-sharing) at the rates applicable prior to*  
17                *the start of the transitional period as payment in full*  
18                *(or at the rates applicable under the replacement plan*  
19                *after the date of the termination of the contract with*  
20                *the group health plan) and not to impose cost-sharing*  
21                *with respect to the individual in an amount that*  
22                *would exceed the cost-sharing that could have been*  
23                *imposed if the contract referred to in subsection (a)(1)*  
24                *had not been terminated.*

1           “(2) *The provider agrees to adhere to the quality*  
2           *assurance standards of the plan responsible for pay-*  
3           *ment under paragraph (1) and to provide to such*  
4           *plan necessary medical information related to the*  
5           *care provided.*

6           “(3) *The provider agrees otherwise to adhere to*  
7           *such plan’s policies and procedures, including proce-*  
8           *dures regarding referrals and obtaining prior author-*  
9           *ization and providing services pursuant to a treat-*  
10          *ment plan (if any) approved by the plan.*

11          “(d) *RULE OF CONSTRUCTION.—Nothing in this sec-*  
12          *tion shall be construed to require the coverage of benefits*  
13          *which would not have been covered if the provider involved*  
14          *remained a participating provider.*

15          “(e) *DEFINITION.—In this section, the term ‘health*  
16          *care provider’ or ‘provider’ means—*

17               “(1) *any individual who is engaged in the deliv-*  
18               *ery of health care services in a State and who is re-*  
19               *quired by State law or regulation to be licensed or*  
20               *certified by the State to engage in the delivery of such*  
21               *services in the State; and*

22               “(2) *any entity that is engaged in the delivery*  
23               *of health care services in a State and that, if it is re-*  
24               *quired by State law or regulation to be licensed or*

1       *certified by the State to engage in the delivery of such*  
 2       *services in the State, is so licensed.*

3       “(f) *COMPREHENSIVE STUDY OF COST, QUALITY AND*  
 4       *COORDINATION OF COVERAGE FOR PATIENTS AT THE END*  
 5       *OF LIFE.—*

6               “(1) *STUDY BY THE MEDICARE PAYMENT ADVI-*  
 7       *SORY COMMISSION.—The Medicare Payment Advisory*  
 8       *Commission shall conduct a study of the costs and*  
 9       *patterns of care for persons with serious and complex*  
 10       *conditions and the possibilities of improving upon*  
 11       *that care to the degree it is triggered by the current*  
 12       *category of terminally ill as such term is used for*  
 13       *purposes of section 1861(dd) of the Social Security*  
 14       *Act (relating to hospice benefits) or of utilizing care*  
 15       *in other payment settings in Medicare.*

16              “(2) *AGENCY FOR HEALTH CARE POLICY AND RE-*  
 17       *SEARCH.—The Agency for Health Care Policy and*  
 18       *Research shall conduct studies of the possible thresh-*  
 19       *olds for major conditions causing serious and complex*  
 20       *illness, their administrative parameters and feasi-*  
 21       *bility, and their impact upon costs and quality.*

22              “(3) *HEALTH CARE FINANCING ADMINISTRA-*  
 23       *TION.—The Health Care Financing Administration*  
 24       *shall conduct studies of the merits of applying similar*  
 25       *thresholds in Medicare+Choice programs, including*

1       *adapting risk adjustment methods to account for this*  
2       *category.*

3               “(4) *INITIAL REPORT.*—

4                       “(A) *IN GENERAL.*—Not later than 12  
5                       *months after the date of enactment of this sec-*  
6                       *tion, the Medicare Payment Advisory Commis-*  
7                       *sion and the Agency for Health Care Policy and*  
8                       *Research shall each prepare and submit to the*  
9                       *Committee on Health, Education, Labor and*  
10                      *Pensions of the Senate a report concerning the*  
11                      *results of the studies conducted under para-*  
12                      *graphs (1) and (2), respectively.*

13                      “(B) *COPY TO SECRETARY.*—Concurrent  
14                      *with the submission of the reports under sub-*  
15                      *paragraph (A), the Medicare Payment Advisory*  
16                      *Commission and the Agency for health Care Pol-*  
17                      *icy and Research shall transmit a copy of the re-*  
18                      *ports under such subparagraph to the Secretary.*

19               “(5) *FINAL REPORT.*—

20                      “(A) *CONTRACT WITH INSTITUTE OF MEDI-*  
21                      *CINE.*—Not later than 1 year after the submis-  
22                      *sion of the reports under paragraph (4), the Sec-*  
23                      *retary of Health and Human Services shall con-*  
24                      *tract with the Institute of Medicine to conduct a*  
25                      *study of the practices and their effects arising*



1       *from the utilization of the category “serious and*  
2       *complex” illness.*

3               *“(B) REPORT.—Not later than 1 year after*  
4       *the date of the execution of the contract referred*  
5       *to in subparagraph (A), the Institute of Medicine*  
6       *shall prepare and submit to the Committee on*  
7       *Health, Education, Labor and Pensions of the*  
8       *Senate a report concerning the study conducted*  
9       *pursuant to such contract.*

10              *“(6) FUNDING.—From funds appropriated to the*  
11       *Department of Health and Human Services, the Sec-*  
12       *retary of Health and Human Services shall make*  
13       *available such funds as the Secretary determines is*  
14       *necessary to carry out this subsection.*

15   **“SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMU-**  
16                   **NICATIONS.**

17              *“(a) IN GENERAL.—Subject to subsection (b), a group*  
18       *health plan (other than a fully insured group health plan*  
19       *and in relation to a participant or beneficiary) shall not*  
20       *prohibit or otherwise restrict a health care professional from*  
21       *advising such a participant or beneficiary who is a patient*  
22       *of the professional about the health status of the participant*  
23       *or beneficiary or medical care or treatment for the condition*  
24       *or disease of the participant or beneficiary, regardless of*  
25       *whether coverage for such care or treatment are provided*

1 *under the contract, if the professional is acting within the*  
 2 *lawful scope of practice.*

3 “(b) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*  
 4 *tion shall be construed as requiring a group health plan*  
 5 *(other than a fully insured group health plan) to provide*  
 6 *specific benefits under the terms of such plan.*

7 **“SEC. 728. PATIENT’S RIGHT TO PRESCRIPTION DRUGS.**

8 “*To the extent that a group health plan (other than*  
 9 *a fully insured group health plan) provides coverage for*  
 10 *benefits with respect to prescription drugs, and limits such*  
 11 *coverage to drugs included in a formulary, the plan shall—*

12 “(1) *ensure the participation of physicians and*  
 13 *pharmacists in developing and reviewing such for-*  
 14 *mulary; and*

15 “(2) *in accordance with the applicable quality*  
 16 *assurance and utilization review standards of the*  
 17 *plan, provide for exceptions from the formulary limi-*  
 18 *tation when a non-formulary alternative is medically*  
 19 *necessary and appropriate.*

20 **“SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE**  
 21 **SERVICES.**

22 “(a) *IN GENERAL.*—*A group health plan (other than*  
 23 *a fully insured group health plan) may not—*

24 “(1) *prohibit or otherwise discourage a partici-*  
 25 *pant or beneficiary from self-paying for behavioral*

1       *health care services once the plan has denied coverage*  
 2       *for such services; or*

3               “(2) *terminate a health care provider because*  
 4       *such provider permits participants or beneficiaries to*  
 5       *self-pay for behavioral health care services—*

6               “(A) *that are not otherwise covered under*  
 7       *the plan; or*

8               “(B) *for which the group health plan pro-*  
 9       *vides limited coverage, to the extent that the*  
 10       *group health plan denies coverage of the services.*

11       “(b) *RULE OF CONSTRUCTION.—Nothing in subsection*  
 12       *(a)(2)(B) shall be construed as prohibiting a group health*  
 13       *plan from terminating a contract with a health care pro-*  
 14       *vider for failure to meet applicable quality standards or*  
 15       *for fraud.*

16       **“SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN**  
 17       **APPROVED CANCER CLINICAL TRIALS.**

18       “(a) *COVERAGE.—*

19               “(1) *IN GENERAL.—If a group health plan (other*  
 20       *than a fully insured group health plan) provides cov-*  
 21       *erage to a qualified individual (as defined in sub-*  
 22       *section (b)), the plan—*

23               “(A) *may not deny the individual partici-*  
 24       *pation in the clinical trial referred to in sub-*  
 25       *section (b)(2);*

1           “(B) subject to subsections (b), (c), and (d)  
 2           may not deny (or limit or impose additional  
 3           conditions on) the coverage of routine patient  
 4           costs for items and services furnished in connec-  
 5           tion with participation in the trial; and

6           “(C) may not discriminate against the in-  
 7           dividual on the basis of the participant’s or  
 8           beneficiaries participation in such trial.

9           “(2) *EXCLUSION OF CERTAIN COSTS.*—For pur-  
 10          poses of paragraph (1)(B), routine patient costs do  
 11          not include the cost of the tests or measurements con-  
 12          ducted primarily for the purpose of the clinical trial  
 13          involved.

14          “(3) *USE OF IN-NETWORK PROVIDERS.*—If one or  
 15          more participating providers is participating in a  
 16          clinical trial, nothing in paragraph (1) shall be con-  
 17          strued as preventing a plan from requiring that a  
 18          qualified individual participate in the trial through  
 19          such a participating provider if the provider will ac-  
 20          cept the individual as a participant in the trial.

21          “(b) *QUALIFIED INDIVIDUAL DEFINED.*—For purposes  
 22          of subsection (a), the term “qualified individual” means an  
 23          individual who is a participant or beneficiary in a group  
 24          health plan and who meets the following conditions:

1           “(1)(A) *The individual has been diagnosed with*  
2           *cancer for which no standard treatment is effective.*

3           “(B) *The individual is eligible to participate in*  
4           *an approved clinical trial according to the trial pro-*  
5           *TOCOL with respect to treatment of such illness.*

6           “(C) *The individual’s participation in the trial*  
7           *offers meaningful potential for significant clinical*  
8           *benefit for the individual.*

9           “(2) *Either—*

10           “(A) *the referring physician is a partici-*  
11           *pating health care professional and has con-*  
12           *cluded that the individual’s participation in*  
13           *such trial would be appropriate based upon the*  
14           *individual meeting the conditions described in*  
15           *paragraph (1); or*

16           “(B) *the participant or beneficiary provides*  
17           *medical and scientific information establishing*  
18           *that the individual’s participation in such trial*  
19           *would be appropriate based upon the individual*  
20           *meeting the conditions described in paragraph*  
21           *(1).*

22           “(c) *PAYMENT.—*

23           “(1) *IN GENERAL.—Under this section a group*  
24           *health plan (other than a fully insured group health*  
25           *plan) shall provide for payment for routine patient*

costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

“(2) *STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.*—

“(A) *IN GENERAL.*—*The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.*

“(B) *FACTORS.*—*In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —*

“(i) *quality of patient care;*

“(ii) *routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and*

1                   “(iii) previous and on-going studies re-  
2                   lating to patient care costs associated with  
3                   participation in clinical trials.

4                   “(C) *PUBLICATION OF NOTICE.*—In car-  
5                   rying out the rulemaking process under this  
6                   paragraph, the Secretary, after consultation with  
7                   organizations representing cancer patients,  
8                   health care practitioners, medical researchers,  
9                   employers, group health plans, manufacturers of  
10                  drugs, biologics and medical devices, medical  
11                  economists, hospitals, and other interested par-  
12                  ties, shall publish notice provided for under sec-  
13                  tion 564(a) of title 5, United States Code, by not  
14                  later than 45 days after the date of the enact-  
15                  ment of this section.

16                  “(D) *TARGET DATE FOR PUBLICATION OF*  
17                  *RULE.*—As part of the notice under subpara-  
18                  graph (C), and for purposes of this paragraph,  
19                  the ‘target date for publication’ (referred to in  
20                  section 564(a)(5) of such title 5) shall be June  
21                  30, 2000.

22                  “(E) *ABBREVIATED PERIOD FOR SUBMIS-*  
23                  *SION OF COMMENTS.*—In applying section 564(c)  
24                  of such title 5 under this paragraph, ‘15 days’  
25                  shall be substituted for ‘30 days’.

1           “(F) *APPOINTMENT OF NEGOTIATED RULE-*  
2           *MAKING COMMITTEE AND FACILITATOR.—The*  
3           *Secretary shall provide for—*

4                   “(i) *the appointment of a negotiated*  
5                   *rulemaking committee under section 565(a)*  
6                   *of such title 5 by not later than 30 days*  
7                   *after the end of the comment period pro-*  
8                   *vided for under section 564(c) of such title*  
9                   *5 (as shortened under subparagraph (E)),*  
10                  *and*

11                  “(ii) *the nomination of a facilitator*  
12                  *under section 566(c) of such title 5 by not*  
13                  *later than 10 days after the date of appoint-*  
14                  *ment of the committee.*

15           “(G) *PRELIMINARY COMMITTEE REPORT.—*  
16           *The negotiated rulemaking committee appointed*  
17           *under subparagraph (F) shall report to the Sec-*  
18           *retary, by not later than March 29, 2000, re-*  
19           *garding the committee’s progress on achieving a*  
20           *consensus with regard to the rulemaking pro-*  
21           *ceeding and whether such consensus is likely to*  
22           *occur before 1 month before the target date for*  
23           *publication of the rule. If the committee reports*  
24           *that the committee has failed to make significant*  
25           *progress towards such consensus or is unlikely to*



1        *reach such consensus by the target date, the Sec-*  
2        *retary may terminate such process and provide*  
3        *for the publication of a rule under this para-*  
4        *graph through such other methods as the Sec-*  
5        *retary may provide.*

6                *“(H) FINAL COMMITTEE REPORT.—If the*  
7        *committee is not terminated under subparagraph*  
8        *(G), the rulemaking committee shall submit a re-*  
9        *port containing a proposed rule by not later*  
10       *than 1 month before the target date of publica-*  
11       *tion.*

12               *“(I) FINAL EFFECT.—The Secretary shall*  
13       *publish a rule under this paragraph in the Fed-*  
14       *eral Register by not later than the target date of*  
15       *publication.*

16               *“(J) PUBLICATION OF RULE AFTER PUBLIC*  
17       *COMMENT.—The Secretary shall provide for con-*  
18       *sideration of such comments and republication of*  
19       *such rule by not later than 1 year after the tar-*  
20       *get date of publication.*

21               *“(K) EFFECTIVE DATE.—The provisions of*  
22       *this paragraph shall apply to group health plans*  
23       *(other than a fully insured group health plan)*  
24       *for plan years beginning on or after January 1,*  
25       *2001.*

1           “(3) *PAYMENT RATE.*—*In the case of covered*  
 2           *items and services provided by—*

3                   “(A) *a participating provider, the payment*  
 4                   *rate shall be at the agreed upon rate, or*

5                   “(B) *a nonparticipating provider, the pay-*  
 6                   *ment rate shall be at the rate the plan would*  
 7                   *normally pay for comparable services under sub-*  
 8                   *paragraph (A).*

9           “(d) *APPROVED CLINICAL TRIAL DEFINED.*—

10                   “(1) *IN GENERAL.*—*In this section, the term ‘ap-*  
 11                   *proved clinical trial’ means a cancer clinical research*  
 12                   *study or cancer clinical investigation approved and*  
 13                   *funded (which may include funding through in-kind*  
 14                   *contributions) by one or more of the following:*

15                           “(A) *The National Institutes of Health.*

16                           “(B) *A cooperative group or center of the*  
 17                           *National Institutes of Health.*

18                           “(C) *Either of the following if the condi-*  
 19                           *tions described in paragraph (2) are met:*

20                                   “(i) *The Department of Veterans Af-*  
 21                                   *fairs.*

22                                   “(ii) *The Department of Defense.*

23                   “(2) *CONDITIONS FOR DEPARTMENTS.*—*The con-*  
 24                   *ditions described in this paragraph, for a study or in-*  
 25                   *vestigation conducted by a Department, are that the*

1       *study or investigation has been reviewed and ap-*  
2       *proved through a system of peer review that the Sec-*  
3       *retary determines—*

4               “(A) *to be comparable to the system of peer*  
5       *review of studies and investigations used by the*  
6       *National Institutes of Health, and*

7               “(B) *assures unbiased review of the highest*  
8       *scientific standards by qualified individuals who*  
9       *have no interest in the outcome of the review.*

10       “(e) *CONSTRUCTION.—Nothing in this section shall be*  
11       *construed to limit a plan’s coverage with respect to clinical*  
12       *trials.*

13       “(f) *PLAN SATISFACTION OF CERTAIN REQUIREMENTS;*  
14       *RESPONSIBILITIES OF FIDUCIARIES.—*

15               “(1) *IN GENERAL.—For purposes of this section,*  
16       *insofar as a group health plan provides benefits in the*  
17       *form of health insurance coverage through a health in-*  
18       *surance issuer, the plan shall be treated as meeting*  
19       *the requirements of this section with respect to such*  
20       *benefits and not be considered as failing to meet such*  
21       *requirements because of a failure of the issuer to meet*  
22       *such requirements so long as the plan sponsor or its*  
23       *representatives did not cause such failure by the*  
24       *issuer.*

1           “(2) *CONSTRUCTION.*—*Nothing in this section*  
 2           *shall be construed to affect or modify the responsibil-*  
 3           *ities of the fiduciaries of a group health plan under*  
 4           *part 4 of subtitle B.*

5           “(g) *STUDY AND REPORT.*—

6           “(1) *STUDY.*—*The Secretary shall study the im-*  
 7            *pact on group health plans for covering routine pa-*  
 8           *tient care costs for individuals who are entitled to*  
 9           *benefits under this section and who are enrolled in an*  
 10           *approved cancer clinical trial program.*

11           “(2) *REPORT TO CONGRESS.*—*Not later than*  
 12           *January 1, 2005, the Secretary shall submit a report*  
 13           *to Congress that contains an assessment of—*

14                   “(A) *any incremental cost to group health*  
 15                   *plans resulting from the provisions of this sec-*  
 16                   *tion;*

17                   “(B) *a projection of expenditures to such*  
 18                   *plans resulting from this section; and*

19                   “(C) *any impact on premiums resulting*  
 20                   *from this section.*

21           **“SEC. 730A. PROHIBITING DISCRIMINATION AGAINST PRO-**  
 22                   **VIDERS.**

23           “(a) *IN GENERAL.*—*A group health plan (other than*  
 24           *a fully insured group health plan) shall not discriminate*  
 25           *with respect to participation or indemnification as to any*

1 provider who is acting within the scope of the provider's  
 2 license or certification under applicable State law, solely  
 3 on the basis of such license or certification. This subsection  
 4 shall not be construed as requiring the coverage under a  
 5 plan of particular benefits or services or to prohibit a plan  
 6 from including providers only to the extent necessary to  
 7 meet the needs of the plan's participants and beneficiaries  
 8 or from establishing any measure designed to maintain  
 9 quality and control costs consistent with the responsibilities  
 10 of the plan.

11 “(b) NO REQUIREMENT FOR ANY WILLING PRO-  
 12 VIDER.—Nothing in this section shall be construed as re-  
 13 quiring a group health plan that offers network coverage  
 14 to include for participation every willing provider or health  
 15 professional who meets the terms and conditions of the plan.

16 **“SEC. 730B. GENERALLY APPLICABLE PROVISION.**

17 “In the case of a group health plan that provides bene-  
 18 fits under 2 or more coverage options, the requirements of  
 19 this subpart shall apply separately with respect to each cov-  
 20 erage option.”.

21 (b) RULE WITH RESPECT TO CERTAIN PLANS.—

22 (1) IN GENERAL.—Notwithstanding any other  
 23 provision of law, health insurance issuers may offer,  
 24 and eligible individuals may purchase, high deduct-  
 25 ible health plans described in section 220(c)(2)(A) of

1        *the Internal Revenue Code of 1986. Effective for the*  
 2        *4-year period beginning on the date of the enactment*  
 3        *of this Act, such health plans shall not be required to*  
 4        *provide payment for any health care items or services*  
 5        *that are exempt from the plan’s deductible.*

6            (2) *EXISTING STATE LAWS.*—*A State law relat-*  
 7        *ing to payment for health care items and services in*  
 8        *effect on the date of enactment of this Act that is pre-*  
 9        *empted under paragraph (1), shall not apply to high*  
 10       *deductible health plans after the expiration of the 4-*  
 11       *year period described in such paragraph unless the*  
 12       *State reenacts such law after such period.*

13        (c) *DEFINITION.*—*Section 733(a) of the Employee Re-*  
 14       *tirement Income Security Act of 1974 (42 U.S.C. 1191(a))*  
 15       *is amended by adding at the end the following:*

16            “(3) *FULLY INSURED GROUP HEALTH PLAN.*—  
 17        *The term ‘fully insured group health plan’ means a*  
 18        *group health plan where benefits under the plan are*  
 19        *provided pursuant to the terms of an arrangement be-*  
 20        *tween a group health plan and a health insurance*  
 21        *issuer and are guaranteed by the health insurance*  
 22        *issuer under a contract or policy of insurance.’”.*

23        (d) *CONFORMING AMENDMENT.*—*The table of contents*  
 24       *in section 1 of such Act is amended—*

“Sec. 721. Patient access to emergency medical care.

“Sec. 722. Offering of choice of coverage options.

“Sec. 723. Patient access to obstetric and gynecological care.

“Sec. 724. Patient access to pediatric care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

“Sec. 727. Protection of patient-provider communications.

“Sec. 728. Patient’s right to prescription drugs.

“Sec. 729. Self-payment for behavioral health care services.

“Sec. 730. Coverage for individuals participating in approved cancer clinical trials.

“Sec. 730A. Prohibiting discrimination against providers.

“Sec. 730B. Generally applicable provision.”.

8 (a) IN GENERAL.—Chapter 100 of the Internal Rev-  
9 enue Code of 1986 is amended—

12 (2) *by inserting after subchapter B the following:*

“Sec. 9821. *Patient access to emergency medical care.*  
“Sec. 9822. *Offering of choice of coverage options.*  
“Sec. 9823. *Patient access to obstetric and gynecological care.*  
“Sec. 9824. *Patient access to pediatric care.*  
“Sec. 9825. *Timely access to specialists.*  
“Sec. 9826. *Continuity of care.*  
“Sec. 9827. *Protection of patient-provider communications.*  
“Sec. 9828. *Patient’s right to prescription drugs.*

*“Sec. 9829. Self-payment for behavioral health care services.*

*“Sec. 9830. Coverage for individuals participating in approved cancer clinical trials.*

*“Sec. 9830A. Prohibiting discrimination against providers.*

*“Sec. 9830B. Generally applicable provision.*

1 **“SEC. 9821. PATIENT ACCESS TO EMERGENCY MEDICAL**  
 2 **CARE.**

3 *“(a) COVERAGE OF EMERGENCY CARE.—*

4 *“(1) IN GENERAL.—To the extent that the group*  
 5 *health plan (other than a fully insured group health*  
 6 *plan) provides coverage for benefits consisting of*  
 7 *emergency medical care (as defined in subsection (c))*  
 8 *or emergency ambulance services, except for items or*  
 9 *services specifically excluded—*

10 *“(A) the plan shall provide coverage for*  
 11 *benefits, without requiring preauthorization, for*  
 12 *emergency medical screening examinations or*  
 13 *emergency ambulance services, to the extent that*  
 14 *a prudent layperson, who possesses an average*  
 15 *knowledge of health and medicine, would deter-*  
 16 *mine such examinations or emergency ambu-*  
 17 *lance services to be necessary to determine wheth-*  
 18 *er emergency medical care (as so defined) is nec-*  
 19 *essary; and*

20 *“(B) the plan shall provide coverage for*  
 21 *benefits, without requiring preauthorization, for*  
 22 *additional emergency medical care to stabilize*  
 23 *an emergency medical condition following an*



1       *emergency medical screening examination (if de-*  
 2       *termined necessary under subparagraph (A)),*  
 3       *pursuant to the definition of stabilize under sec-*  
 4       *tion 1867(e)(3) of the Social Security Act (42*  
 5       *U.S.C. 1395dd(e)(3)).*

6       “(2) *REIMBURSEMENT FOR CARE TO MAINTAIN*  
 7       *MEDICAL STABILITY.—*

8               “(A) *IN GENERAL.—In the case of services*  
 9       *provided to a participant or beneficiary by a*  
 10       *nonparticipating provider in order to maintain*  
 11       *the medical stability of the participant or bene-*  
 12       *ficiary, the group health plan involved shall pro-*  
 13       *vide for reimbursement with respect to such serv-*  
 14       *ices if—*

15               “(i) *coverage for services of the type*  
 16       *furnished is available under the group*  
 17       *health plan;*

18               “(ii) *the services were provided for care*  
 19       *related to an emergency medical condition*  
 20       *and in an emergency department in order*  
 21       *to maintain the medical stability of the*  
 22       *participant or beneficiary; and*

23               “(iii) *the nonparticipating provider*  
 24       *contacted the plan regarding approval for*  
 25       *such services.*

1           “(B) *FAILURE TO RESPOND.*—If a group  
 2           health plan fails to respond within 1 hours of  
 3           being contacted in accordance with subpara-  
 4           graph (A)(iii), then the plan shall be liable for  
 5           the cost of services provided by the nonpartici-  
 6           pating provider in order to maintain the sta-  
 7           bility of the participant or beneficiary.

8           “(C) *LIMITATION.*—The liability of a group  
 9           health plan to provide reimbursement under sub-  
 10          paragraph (A) shall terminate when the plan  
 11          has contacted the nonparticipating provider to  
 12          arrange for discharge or transfer.

13          “(D) *LIABILITY OF PARTICIPANT.*—A par-  
 14          ticipant or beneficiary shall not be liable for the  
 15          costs of services to which subparagraph (A) in an  
 16          amount that exceeds the amount of liability that  
 17          would be incurred if the services were provided  
 18          by a participating health care provider with  
 19          prior authorization by the plan.

20          “(b) *IN-NETWORK UNIFORM COSTS-SHARING AND*  
 21          *OUT-OF-NETWORK CARE.*—

22               “(1) *IN-NETWORK UNIFORM COST-SHARING.*—  
 23          Nothing in this section shall be construed as pre-  
 24          venting a group health plan (other than a fully in-  
 25          sured group health plan) from imposing any form of

1     *cost-sharing applicable to any participant or bene-*  
2     *ficiary (including coinsurance, copayments,*  
3     *deductibles, and any other charges) in relation to cov-*  
4     *erage for benefits described in subsection (a), if such*  
5     *form of cost-sharing is uniformly applied under such*  
6     *plan, with respect to similarly situated participants*  
7     *and beneficiaries, to all benefits consisting of emer-*  
8     *gency medical care (as defined in subsection (c)) pro-*  
9     *vided to such similarly situated participants and*  
10    *beneficiaries under the plan, and such cost-sharing is*  
11    *disclosed in accordance with section 9814.*

12           “(2) *OUT-OF-NETWORK CARE.*—*If a group health*  
13    *plan (other than a fully insured group health plan)*  
14    *provides any benefits with respect to emergency med-*  
15    *ical care (as defined in subsection (c)), the plan shall*  
16    *cover emergency medical care under the plan in a*  
17    *manner so that, if such care is provided to a partici-*  
18    *part or beneficiary by a nonparticipating health care*  
19    *provider, the participant or beneficiary is not liable*  
20    *for amounts that exceed any form of cost-sharing (in-*  
21    *cluding coinsurance, copayments, deductibles, and*  
22    *any other charges) that would be incurred if the serv-*  
23    *ices were provided by a participating provider.*

24           “(c) *DEFINITION OF EMERGENCY MEDICAL CARE.*—*In*  
25    *this section:*

1           “(1) *IN GENERAL.*—*The term ‘emergency medical*  
2           *care’ means, with respect to a participant or bene-*  
3           *ficiary under a group health plan (other than a fully*  
4           *insured group health plan), covered inpatient and*  
5           *outpatient services that—*

6                     *“(A) are furnished by any provider, includ-*  
7                     *ing a nonparticipating provider, that is quali-*  
8                     *fied to furnish such services; and*

9                     *“(B) are needed to evaluate or stabilize (as*  
10                    *such term is defined in section 1867(e)(3) of the*  
11                    *Social Security Act (42 U.S.C. 1395dd)(e)(3))*  
12                    *an emergency medical condition (as defined in*  
13                    *paragraph (2)).*

14           “(2) *EMERGENCY MEDICAL CONDITION.*—*The*  
15           *term ‘emergency medical condition’ means a medical*  
16           *condition manifesting itself by acute symptoms of suf-*  
17           *ficient severity (including severe pain) such that a*  
18           *prudent layperson, who possesses an average knowl-*  
19           *edge of health and medicine, could reasonably expect*  
20           *the absence of immediate medical attention to result*  
21           *in—*

22                     *“(A) placing the health of the participant or*  
23                     *beneficiary (or, with respect to a pregnant*  
24                     *woman, the health of the woman or her unborn*  
25                     *child) in serious jeopardy,*

1                   “(B) *serious impairment to bodily func-*  
 2                   *tions, or*

3                   “(C) *serious dysfunction of any bodily*  
 4                   *organ or part.*

5   **“SEC. 9822. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

6           “(a) *REQUIREMENT.—*

7                   “(1) *OFFERING OF POINT-OF-SERVICE COVERAGE*  
 8                   *OPTION.—Except as provided in paragraph (2), if a*  
 9                   *group health plan (other than a fully insured group*  
 10                   *health plan) provides coverage for benefits only*  
 11                   *through a defined set of participating health care pro-*  
 12                   *fessionals, the plan shall offer the participant the op-*  
 13                   *tion to purchase point-of-service coverage (as defined*  
 14                   *in subsection (b)) for all such benefits for which cov-*  
 15                   *erage is otherwise so limited. Such option shall be*  
 16                   *made available to the participant at the time of en-*  
 17                   *rollment under the plan and at such other times as*  
 18                   *the plan offers the participant a choice of coverage op-*  
 19                   *tions.*

20                   “(2) *EXCEPTION IN CASE OF LACK OF AVAIL-*  
 21                   *ABILITY.—Paragraph (1) shall not apply with respect*  
 22                   *to a group health plan (other than a fully insured*  
 23                   *group health plan) if care relating to the point-of-*  
 24                   *service coverage would not be available and accessible*  
 25                   *to the participant with reasonable promptness (con-*

1        *sistent with section 1301(b)(4) of the Public Health*  
 2        *Service Act (42 U.S.C. 300e(b)(4))).*

3        “(b) *POINT-OF-SERVICE COVERAGE DEFINED.*—*In*  
 4        *this section, the term ‘point-of-service coverage’ means, with*  
 5        *respect to benefits covered under a group health plan (other*  
 6        *than a fully insured group health plan), coverage of such*  
 7        *benefits when provided by a nonparticipating health care*  
 8        *professional.*

9        “(c) *SMALL EMPLOYER EXEMPTION.*—

10            “(1) *IN GENERAL.*—*This section shall not apply*  
 11        *to any group health plan (other than a fully insured*  
 12        *group health plan) of a small employer.*

13            “(2) *SMALL EMPLOYER.*—*For purposes of para-*  
 14        *graph (1), the term ‘small employer’ means, in con-*  
 15        *nection with a group health plan (other than a fully*  
 16        *insured group health plan) with respect to a calendar*  
 17        *year and a plan year, an employer who employed an*  
 18        *average of at least 2 but not more than 50 employees*  
 19        *on business days during the preceding calendar year*  
 20        *and who employs at least 2 employees on the first day*  
 21        *of the plan year. For purposes of this paragraph, the*  
 22        *provisions of subparagraph (C) of section*  
 23        *4980D(d)(2) shall apply in determining employer*  
 24        *size.*

1       “(d) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*  
 2       *tion shall be construed—*

3               “(1) *as requiring coverage for benefits for a par-*  
 4       *ticular type of health care professional;*

5               “(2) *as requiring an employer to pay any costs*  
 6       *as a result of this section or to make equal contribu-*  
 7       *tions with respect to different health coverage options;*

8               “(3) *as preventing a group health plan (other*  
 9       *than a fully insured group health plan) from impos-*  
 10       *ing higher premiums or cost-sharing on a participant*  
 11       *for the exercise of a point-of-service coverage option;*  
 12       *or*

13               “(4) *to require that a group health plan (other*  
 14       *than a fully insured group health plan) include cov-*  
 15       *erage of health care professionals that the plan ex-*  
 16       *cludes because of fraud, quality of care, or other simi-*  
 17       *lar reasons with respect to such professionals.*

18       **“SEC. 9823. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**  
 19               **LOGICAL CARE.**

20       “(a) *GENERAL RIGHTS.*—

21               “(1) *WAIVER OF PLAN REFERRAL REQUIRE-*  
 22       *MENT.*—*If a group health plan described in subsection*  
 23       *(b) requires a referral to obtain coverage for specialty*  
 24       *care, the plan shall waive the referral requirement in*  
 25       *the case of a female participant or beneficiary who*

1        *seeks coverage for obstetrical care and related follow-*  
 2        *up obstetrical care or routine gynecological care (such*  
 3        *as preventive gynecological care).*

4            “(2) *RELATED ROUTINE CARE.*—*With respect to*  
 5        *a participant or beneficiary described in paragraph*  
 6        *(1), a group health plan described in subsection (b)*  
 7        *shall treat the ordering of other routine care that is*  
 8        *related to routine gynecologic care, by a physician*  
 9        *who specializes in obstetrics and gynecology as the*  
 10       *authorization of the primary care provider for such*  
 11       *other care.*

12          “(b) *APPLICATION OF SECTION.*—*A group health plan*  
 13       *described in this subsection is a group health plan (other*  
 14       *than a fully insured group health plan), that—*

15            “(1) *provides coverage for obstetric care (such as*  
 16        *pregnancy-related services) or routine gynecologic*  
 17        *care (such as preventive women’s health examina-*  
 18        *tions); and*

19            “(2) *requires the designation by a participant or*  
 20        *beneficiary of a participating primary care provider*  
 21        *who is not a physician who specializes in obstetrics*  
 22        *or gynecology.*

23          “(c) *RULES OF CONSTRUCTION.*—*Nothing in this sec-*  
 24       *tion shall be construed—*



1           “(1) as waiving any coverage requirement relat-  
 2           ing to medical necessity or appropriateness with re-  
 3           spect to the coverage of obstetric or gynecologic care  
 4           described in subsection (a);

5           “(2) to preclude the plan from requiring that the  
 6           physician who specializes in obstetrics or gynecology  
 7           notify the designated primary care provider or the  
 8           plan of treatment decisions;

9           “(3) to preclude a group health plan from allow-  
 10          ing health care professionals other than physicians to  
 11          provide routine obstetric or routine gynecologic care;  
 12          or

13          “(4) to preclude a group health plan from per-  
 14          mitting a physician who specializes in obstetrics and  
 15          gynecology from being a primary care provider under  
 16          the plan.

17       **“SEC. 9824. PATIENT ACCESS TO PEDIATRIC CARE.**

18          “(a) *IN GENERAL.*—In the case of a group health plan  
 19          (other than a fully insured group health plan) that provides  
 20          coverage for routine pediatric care and that requires the  
 21          designation by a participant or beneficiary of a partici-  
 22          pating primary care provider, if the designated primary  
 23          care provider is not a physician who specializes in  
 24          pediatrics—

1           “(1) the plan may not require authorization or  
 2           referral by the primary care provider in order for a  
 3           participant or beneficiary to obtain coverage for rou-  
 4           tine pediatric care; and

5           “(2) the plan shall treat the ordering of other  
 6           routine care related to routine pediatric care by such  
 7           a specialist as having been authorized by the des-  
 8           ignated primary care provider.

9           “(b) *RULES OF CONSTRUCTION.*—Nothing in sub-  
 10          section (a) shall be construed—

11           “(1) as waiving any coverage requirement relat-  
 12           ing to medical necessity or appropriateness with re-  
 13           spect to the coverage of any pediatric care provided  
 14           to, or ordered for, a participant or beneficiary;

15           “(2) to preclude a group health plan from re-  
 16           quiring that a specialist described in subsection (a)  
 17           notify the designated primary care provider or the  
 18           plan of treatment decisions; or

19           “(3) to preclude a group health plan from allow-  
 20           ing health care professionals other than physicians to  
 21           provide routine pediatric care.

22          **“SEC. 9825. TIMELY ACCESS TO SPECIALISTS.**

23           “(a) *TIMELY ACCESS.*—

24           “(1) *IN GENERAL.*—A group health plan (other  
 25           than a fully insured group health plan) shall ensure

1     *that participants and beneficiaries have timely, in*  
 2     *accordance with the medical exigencies of the case, ac-*  
 3     *cess to primary and specialty health care profes-*  
 4     *sionals who are appropriate to the condition of the*  
 5     *participant or beneficiary, when such care is covered*  
 6     *under the plan. Such access may be provided through*  
 7     *contractual arrangements with specialized providers*  
 8     *outside of the network of the plan.*

9             “(2) *RULE OF CONSTRUCTION.*—*Nothing in*  
 10     *paragraph (1) shall be construed—*

11                 “(A) *to require the coverage under a group*  
 12             *health plan of particular benefits or services or*  
 13             *to prohibit a plan from including providers only*  
 14             *to the extent necessary to meet the needs of the*  
 15             *plan’s participants or beneficiaries or from es-*  
 16             *tablishing any measure designed to maintain*  
 17             *quality and control costs consistent with the re-*  
 18             *sponsibilities of the plan; or*

19                 “(B) *to override any State licensure or*  
 20             *scope-of-practice law.*

21             “(b) *TREATMENT PLANS.*—

22                 “(1) *IN GENERAL.*—*Nothing in this section shall*  
 23             *be construed to prohibit a group health plan (other*  
 24             *than a fully insured group health plan) from requir-*

1        *ing that specialty care be provided pursuant to a*  
2        *treatment plan so long as the treatment plan is—*

3                *“(A) developed by the specialist, in con-*  
4                *sultation with the case manager or primary care*  
5                *provider, and the participant or beneficiary;*

6                *“(B) approved by the plan in a timely*  
7                *manner in accordance with the medical exigen-*  
8                *cies of the case; and*

9                *“(C) in accordance with the applicable*  
10               *quality assurance and utilization review stand-*  
11               *ards of the plan.*

12               *“(2) NOTIFICATION.—Nothing in paragraph (1)*  
13               *shall be construed as prohibiting a plan from requir-*  
14               *ing the specialist to provide the case manager or pri-*  
15               *mary care provider with regular updates on the spe-*  
16               *cialty care provided, as well as all other necessary*  
17               *medical information.*

18               *“(c) REFERRALS.—Nothing in this section shall be*  
19               *construed to prohibit a plan from requiring an authoriza-*  
20               *tion by the case manager or primary care provider of the*  
21               *participant or beneficiary in order to obtain coverage for*  
22               *specialty services so long as such authorization is for an*  
23               *adequate number of referrals.*

24               *“(d) SPECIALTY CARE DEFINED.—For purposes of this*  
25               *subsection, the term ‘specialty care’ means, with respect to*

1 *a condition, care and treatment provided by a health care*  
 2 *practitioner, facility, or center (such as a center of excel-*  
 3 *lence) that has adequate expertise (including age-appro-*  
 4 *priate expertise) through appropriate training and experi-*  
 5 *ence.*

6 **“SEC. 9826. CONTINUITY OF CARE.**

7       “(a) *IN GENERAL.*—

8               “(1) *TERMINATION OF PROVIDER.*—*If a contract*  
 9 *between a group health plan (other than a fully in-*  
 10 *sured group health plan) and a health care provider*  
 11 *is terminated (as defined in paragraph (2)), or bene-*  
 12 *fits or coverage provided by a health care provider are*  
 13 *terminated because of a change in the terms of pro-*  
 14 *vider participation in such group health plan, and*  
 15 *an individual who is a participant or beneficiary in*  
 16 *the plan is undergoing a course of treatment from the*  
 17 *provider at the time of such termination, the plan*  
 18 *shall—*

19               “(A) *notify the individual on a timely basis*  
 20 *of such termination;*

21               “(B) *provide the individual with an oppor-*  
 22 *tunity to notify the plan of a need for transi-*  
 23 *tional care; and*

24               “(C) *in the case of termination described in*  
 25 *paragraph (2), (3), or (4) of subsection (b), and*

1           *subject to subsection (c), permit the individual to*  
 2           *continue or be covered with respect to the course*  
 3           *of treatment with the provider’s consent during*  
 4           *a transitional period (as provided under sub-*  
 5           *section (b)).*

6           “(2) *TERMINATED.*—*In this section, the term*  
 7           *‘terminated’ includes, with respect to a contract, the*  
 8           *expiration or nonrenewal of the contract by the group*  
 9           *health plan, but does not include a termination of the*  
 10           *contract by the plan for failure to meet applicable*  
 11           *quality standards or for fraud.*

12           “(3) *CONTRACTS.*—*For purposes of this section,*  
 13           *the term ‘contract between a group health plan (other*  
 14           *than a fully insured group health plan) and a health*  
 15           *care provider’ shall include a contract between such*  
 16           *a plan and an organized network of providers.*

17           “(b) *TRANSITIONAL PERIOD.*—

18           “(1) *GENERAL RULE.*—*Except as provided in*  
 19           *paragraph (3), the transitional period under this sub-*  
 20           *section shall permit the participant or beneficiary to*  
 21           *extend the coverage involved for up to 90 days from*  
 22           *the date of the notice described in subsection (a)(1)(A)*  
 23           *of the provider’s termination.*

24           “(2) *INSTITUTIONAL CARE.*—*Subject to para-*  
 25           *graph (1), the transitional period under this sub-*

1      *section for institutional or inpatient care from a pro-*  
2      *vider shall extend until the discharge or termination*  
3      *of the period of institutionalization and also shall in-*  
4      *clude institutional care provided within a reasonable*  
5      *time of the date of termination of the provider status*  
6      *if the care was scheduled before the date of the an-*  
7      *nouncement of the termination of the provider status*  
8      *under subsection (a)(1)(A) or if the individual on*  
9      *such date was on an established waiting list or other-*  
10     *wise scheduled to have such care.*

11            *“(3) PREGNANCY.—Notwithstanding paragraph*  
12     *(1), if—*

13                    *“(A) a participant or beneficiary has en-*  
14                    *tered the second trimester of pregnancy at the*  
15                    *time of a provider’s termination of participa-*  
16                    *tion; and*

17                    *“(B) the provider was treating the preg-*  
18                    *nancy before the date of the termination;*  
19     *the transitional period under this subsection with re-*  
20     *spect to provider’s treatment of the pregnancy shall*  
21     *extend through the provision of post-partum care di-*  
22     *rectly related to the delivery.*

23            *“(4) TERMINAL ILLNESS.—Notwithstanding*  
24     *paragraph (1), if—*

1           “(A) a participant or beneficiary was deter-  
2           mined to be terminally ill (as determined under  
3           section 1861(dd)(3)(A) of the Social Security  
4           Act) prior to a provider’s termination of partici-  
5           pation; and

6           “(B) the provider was treating the terminal  
7           illness before the date of termination;  
8           the transitional period under this subsection shall be  
9           for care directly related to the treatment of the ter-  
10          minal illness and shall extend for the remainder of  
11          the individual’s life for such care.

12          “(c) *PERMISSIBLE TERMS AND CONDITIONS.*—A group  
13          health plan (other than a fully insured group health plan)  
14          may condition coverage of continued treatment by a pro-  
15          vider under subsection (a)(1)(C) upon the provider agreeing  
16          to the following terms and conditions:

17               “(1) The provider agrees to accept reimburse-  
18               ment from the plan and individual involved (with re-  
19               spect to cost-sharing) at the rates applicable prior to  
20               the start of the transitional period as payment in full  
21               (or at the rates applicable under the replacement plan  
22               after the date of the termination of the contract with  
23               the group health plan) and not to impose cost-sharing  
24               with respect to the individual in an amount that  
25               would exceed the cost-sharing that could have been



1        *imposed if the contract referred to in subsection (a)(1)*  
2        *had not been terminated.*

3                *“(2) The provider agrees to adhere to the quality*  
4        *assurance standards of the plan responsible for pay-*  
5        *ment under paragraph (1) and to provide to such*  
6        *plan necessary medical information related to the*  
7        *care provided.*

8                *“(3) The provider agrees otherwise to adhere to*  
9        *such plan’s policies and procedures, including proce-*  
10       *dures regarding referrals and obtaining prior author-*  
11       *ization and providing services pursuant to a treat-*  
12       *ment plan (if any) approved by the plan.*

13               *“(d) RULE OF CONSTRUCTION.—Nothing in this sec-*  
14       *tion shall be construed to require the coverage of benefits*  
15       *which would not have been covered if the provider involved*  
16       *remained a participating provider.*

17               *“(e) DEFINITION.—In this section, the term ‘health*  
18       *care provider’ or ‘provider’ means—*

19                        *“(1) any individual who is engaged in the deliv-*  
20       *ery of health care services in a State and who is re-*  
21       *quired by State law or regulation to be licensed or*  
22       *certified by the State to engage in the delivery of such*  
23       *services in the State; and*

24                        *“(2) any entity that is engaged in the delivery*  
25       *of health care services in a State and that, if it is re-*

1        *quired by State law or regulation to be licensed or*  
 2        *certified by the State to engage in the delivery of such*  
 3        *services in the State, is so licensed.*

4        “(f) *COMPREHENSIVE STUDY OF COST, QUALITY AND*  
 5        *COORDINATION OF COVERAGE FOR PATIENTS AT THE END*  
 6        *OF LIFE.—*

7                “(1) *STUDY BY THE MEDICARE PAYMENT ADVI-*  
 8        *SORY COMMISSION.—The Medicare Payment Advisory*  
 9        *Commission shall conduct a study of the costs and*  
 10        *patterns of care for persons with serious and complex*  
 11        *conditions and the possibilities of improving upon*  
 12        *that care to the degree it is triggered by the current*  
 13        *category of terminally ill as such term is used for*  
 14        *purposes of section 1861(dd) of the Social Security*  
 15        *Act (relating to hospice benefits) or of utilizing care*  
 16        *in other payment settings in Medicare.*

17                “(2) *AGENCY FOR HEALTH CARE POLICY AND RE-*  
 18        *SEARCH.—The Agency for Health Care Policy and*  
 19        *Research shall conduct studies of the possible thresh-*  
 20        *olds for major conditions causing serious and complex*  
 21        *illness, their administrative parameters and feasi-*  
 22        *bility, and their impact upon costs and quality.*

23                “(3) *HEALTH CARE FINANCING ADMINISTRA-*  
 24        *TION.—The Health Care Financing Administration*  
 25        *shall conduct studies of the merits of applying similar*

1 *thresholds in Medicare+Choice programs, including*  
 2 *adapting risk adjustment methods to account for this*  
 3 *category.*

4 “(4) *INITIAL REPORT.*—

5 “(A) *IN GENERAL.*—Not later than 12  
 6 months after the date of enactment of this sec-  
 7 tion, the Medicare Payment Advisory Commis-  
 8 sion and the Agency for Health Care Policy and  
 9 Research shall each prepare and submit to the  
 10 Committee on Health, Education, Labor and  
 11 Pensions of the Senate a report concerning the  
 12 results of the studies conducted under para-  
 13 graphs (1) and (2), respectively.

14 “(B) *COPY TO SECRETARY.*—Concurrent  
 15 with the submission of the reports under sub-  
 16 paragraph (A), the Medicare Payment Advisory  
 17 Commission and the Agency for health Care Pol-  
 18 icy and Research shall transmit a copy of the re-  
 19 ports under such subparagraph to the Secretary.

20 “(5) *FINAL REPORT.*—

21 “(A) *CONTRACT WITH INSTITUTE OF MEDI-*  
 22 *CINE.*—Not later than 1 year after the submis-  
 23 sion of the reports under paragraph (4), the Sec-  
 24 retary of Health and Human Services shall con-  
 25 tract with the Institute of Medicine to conduct a

1           *study of the practices and their effects arising*  
2           *from the utilization of the category “serious and*  
3           *complex” illness.*

4           “(B) *REPORT.*—Not later than 1 year after  
5           *the date of the execution of the contract referred*  
6           *to in subparagraph (A), the Institute of Medicine*  
7           *shall prepare and submit to the Committee on*  
8           *Health, Education, Labor and Pensions of the*  
9           *Senate a report concerning the study conducted*  
10          *pursuant to such contract.*

11          “(6) *FUNDING.*—From funds appropriated to the  
12          *Department of Health and Human Services, the Sec-*  
13          *retary of Health and Human Services shall make*  
14          *available such funds as the Secretary determines is*  
15          *necessary to carry out this subsection.*

16   **“SEC. 9827. PROTECTION OF PATIENT-PROVIDER COMMU-**  
17                   **NICATIONS.**

18          “(a) *IN GENERAL.*—Subject to subsection (b), a group  
19          *health plan (other than a fully insured group health plan*  
20          *and in relation to a participant or beneficiary) shall not*  
21          *prohibit or otherwise restrict a health care professional from*  
22          *advising such a participant or beneficiary who is a patient*  
23          *of the professional about the health status of the participant*  
24          *or beneficiary or medical care or treatment for the condition*  
25          *or disease of the participant or beneficiary, regardless of*

1 *whether coverage for such care or treatment are provided*  
 2 *under the contract, if the professional is acting within the*  
 3 *lawful scope of practice.*

4 “(b) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*  
 5 *tion shall be construed as requiring a group health plan*  
 6 *(other than a fully insured group health plan) to provide*  
 7 *specific benefits under the terms of such plan.*

8 **“SEC. 9828. PATIENT’S RIGHT TO PRESCRIPTION DRUGS.**

9 “*To the extent that a group health plan (other than*  
 10 *a fully insured group health plan) provides coverage for*  
 11 *benefits with respect to prescription drugs, and limits such*  
 12 *coverage to drugs included in a formulary, the plan shall—*

13 “(1) *ensure the participation of physicians and*  
 14 *pharmacists in developing and reviewing such for-*  
 15 *mulary; and*

16 “(2) *in accordance with the applicable quality*  
 17 *assurance and utilization review standards of the*  
 18 *plan, provide for exceptions from the formulary limi-*  
 19 *tation when a non-formulary alternative is medically*  
 20 *necessary and appropriate.*

21 **“SEC. 9829. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE**  
 22 **SERVICES.**

23 “(a) *IN GENERAL.*—*A group health plan (other than*  
 24 *a fully insured group health plan) may not—*

1           “(1) prohibit or otherwise discourage a partici-  
 2           pant or beneficiary from self-paying for behavioral  
 3           health care services once the plan has denied coverage  
 4           for such services; or

5           “(2) terminate a health care provider because  
 6           such provider permits participants or beneficiaries to  
 7           self-pay for behavioral health care services—

8           “(A) that are not otherwise covered under  
 9           the plan; or

10           “(B) for which the group health plan pro-  
 11           vides limited coverage, to the extent that the  
 12           group health plan denies coverage of the services.

13           “(b) *RULE OF CONSTRUCTION.*—Nothing in subsection  
 14           (a)(2)(B) shall be construed as prohibiting a group health  
 15           plan from terminating a contract with a health care pro-  
 16           vider for failure to meet applicable quality standards or  
 17           for fraud.

18           **“SEC. 9830. COVERAGE FOR INDIVIDUALS PARTICIPATING**  
 19           **IN APPROVED CANCER CLINICAL TRIALS.**

20           “(a) *COVERAGE.*—

21           “(1) *IN GENERAL.*—If a group health plan (other  
 22           than a fully insured group health plan) provides cov-  
 23           erage to a qualified individual (as defined in sub-  
 24           section (b)), the plan—

1           “(A) may not deny the individual partici-  
2           pation in the clinical trial referred to in sub-  
3           section (b)(2);

4           “(B) subject to subsections (b), (c), and (d)  
5           may not deny (or limit or impose additional  
6           conditions on) the coverage of routine patient  
7           costs for items and services furnished in connec-  
8           tion with participation in the trial; and

9           “(C) may not discriminate against the in-  
10          dividual on the basis of the participant’s or  
11          beneficiaries participation in such trial.

12          “(2) *EXCLUSION OF CERTAIN COSTS.*—For pur-  
13          poses of paragraph (1)(B), routine patient costs do  
14          not include the cost of the tests or measurements con-  
15          ducted primarily for the purpose of the clinical trial  
16          involved.

17          “(3) *USE OF IN-NETWORK PROVIDERS.*—If one or  
18          more participating providers is participating in a  
19          clinical trial, nothing in paragraph (1) shall be con-  
20          strued as preventing a plan from requiring that a  
21          qualified individual participate in the trial through  
22          such a participating provider if the provider will ac-  
23          cept the individual as a participant in the trial.

24          “(b) *QUALIFIED INDIVIDUAL DEFINED.*—For purposes  
25          of subsection (a), the term “qualified individual” means an

1 *individual who is a participant or beneficiary in a group*  
2 *health plan and who meets the following conditions:*

3           “(1)(A) *The individual has been diagnosed with*  
4 *cancer for which no standard treatment is effective.*

5           “(B) *The individual is eligible to participate in*  
6 *an approved clinical trial according to the trial pro-*  
7 *tol with respect to treatment of such illness.*

8           “(C) *The individual’s participation in the trial*  
9 *offers meaningful potential for significant clinical*  
10 *benefit for the individual.*

11           “(2) *Either—*

12                   “(A) *the referring physician is a partici-*  
13 *pating health care professional and has con-*  
14 *cluded that the individual’s participation in*  
15 *such trial would be appropriate based upon the*  
16 *individual meeting the conditions described in*  
17 *paragraph (1); or*

18                   “(B) *the participant or beneficiary provides*  
19 *medical and scientific information establishing*  
20 *that the individual’s participation in such trial*  
21 *would be appropriate based upon the individual*  
22 *meeting the conditions described in paragraph*  
23 *(1).*

24           “(c) *PAYMENT.—*



1           “(1) *IN GENERAL.*—Under this section a group  
2           health plan (other than a fully insured group health  
3           plan) shall provide for payment for routine patient  
4           costs described in subsection (a)(2) but is not required  
5           to pay for costs of items and services that are reason-  
6           ably expected to be paid for by the sponsors of an ap-  
7           proved clinical trial.

8           “(2) *STANDARDS FOR DETERMINING ROUTINE*  
9           *PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL*  
10          *PARTICIPATION.*—

11           “(A) *IN GENERAL.*—The Secretary shall es-  
12          tablish, on an expedited basis and using a nego-  
13          tiated rulemaking process under subchapter III  
14          of chapter 5 of title 5, United States Code, stand-  
15          ards relating to the coverage of routine patient  
16          costs for individuals participating in clinical  
17          trials that group health plans must meet under  
18          this section.

19           “(B) *FACTORS.*—In establishing routine pa-  
20          tient cost standards under subparagraph (A), the  
21          Secretary shall consult with interested parties  
22          and take into account —

23                   “(i) quality of patient care;

24                   “(ii) routine patient care costs versus  
25                  costs associated with the conduct of clinical

1            *trials, including unanticipated patient care*  
2            *costs as a result of participation in clinical*  
3            *trials; and*

4            *“(iii) previous and on-going studies re-*  
5            *lating to patient care costs associated with*  
6            *participation in clinical trials.*

7            *“(C) PUBLICATION OF NOTICE.—In car-*  
8            *rying out the rulemaking process under this*  
9            *paragraph, the Secretary, after consultation with*  
10           *organizations representing cancer patients,*  
11           *health care practitioners, medical researchers,*  
12           *employers, group health plans, manufacturers of*  
13           *drugs, biologics and medical devices, medical*  
14           *economists, hospitals, and other interested par-*  
15           *ties, shall publish notice provided for under sec-*  
16           *tion 564(a) of title 5, United States Code, by not*  
17           *later than 45 days after the date of the enact-*  
18           *ment of this section.*

19           *“(D) TARGET DATE FOR PUBLICATION OF*  
20           *RULE.—As part of the notice under subpara-*  
21           *graph (C), and for purposes of this paragraph,*  
22           *the ‘target date for publication’ (referred to in*  
23           *section 564(a)(5) of such title 5) shall be June*  
24           *30, 2000.*

1           “(E) *ABBREVIATED PERIOD FOR SUBMIS-*  
 2           *SION OF COMMENTS.*—*In applying section 564(c)*  
 3           *of such title 5 under this paragraph, ‘15 days’*  
 4           *shall be substituted for ‘30 days’.*

5           “(F) *APPOINTMENT OF NEGOTIATED RULE-*  
 6           *MAKING COMMITTEE AND FACILITATOR.*—*The*  
 7           *Secretary shall provide for—*

8                   “(i) *the appointment of a negotiated*  
 9                   *rulemaking committee under section 565(a)*  
 10                  *of such title 5 by not later than 30 days*  
 11                  *after the end of the comment period pro-*  
 12                  *vided for under section 564(c) of such title*  
 13                  *5 (as shortened under subparagraph (E)),*  
 14                  *and*

15                  “(ii) *the nomination of a facilitator*  
 16                  *under section 566(c) of such title 5 by not*  
 17                  *later than 10 days after the date of appoint-*  
 18                  *ment of the committee.*

19           “(G) *PRELIMINARY COMMITTEE REPORT.*—  
 20           *The negotiated rulemaking committee appointed*  
 21           *under subparagraph (F) shall report to the Sec-*  
 22           *retary, by not later than March 29, 2000, re-*  
 23           *garding the committee’s progress on achieving a*  
 24           *consensus with regard to the rulemaking pro-*  
 25           *ceeding and whether such consensus is likely to*

1        *occur before 1 month before the target date for*  
2        *publication of the rule. If the committee reports*  
3        *that the committee has failed to make significant*  
4        *progress towards such consensus or is unlikely to*  
5        *reach such consensus by the target date, the Sec-*  
6        *retary may terminate such process and provide*  
7        *for the publication of a rule under this para-*  
8        *graph through such other methods as the Sec-*  
9        *retary may provide.*

10        *“(H) FINAL COMMITTEE REPORT.—If the*  
11        *committee is not terminated under subparagraph*  
12        *(G), the rulemaking committee shall submit a re-*  
13        *port containing a proposed rule by not later*  
14        *than 1 month before the target date of publica-*  
15        *tion.*

16        *“(I) FINAL EFFECT.—The Secretary shall*  
17        *publish a rule under this paragraph in the Fed-*  
18        *eral Register by not later than the target date of*  
19        *publication.*

20        *“(J) PUBLICATION OF RULE AFTER PUBLIC*  
21        *COMMENT.—The Secretary shall provide for con-*  
22        *sideration of such comments and republication of*  
23        *such rule by not later than 1 year after the tar-*  
24        *get date of publication.*

1           “(K) *EFFECTIVE DATE.*—*The provisions of*  
 2           *this paragraph shall apply to group health plans*  
 3           *(other than a fully insured group health plan)*  
 4           *for plan years beginning on or after January 1,*  
 5           *2001.*

6           “(3) *PAYMENT RATE.*—*In the case of covered*  
 7           *items and services provided by—*

8                 “(A) *a participating provider, the payment*  
 9                 *rate shall be at the agreed upon rate, or*

10                “(B) *a nonparticipating provider, the pay-*  
 11                *ment rate shall be at the rate the plan would*  
 12                *normally pay for comparable services under sub-*  
 13                *paragraph (A).*

14           “(d) *APPROVED CLINICAL TRIAL DEFINED.*—

15                “(1) *IN GENERAL.*—*In this section, the term ‘ap-*  
 16                *proved clinical trial’ means a cancer clinical research*  
 17                *study or cancer clinical investigation approved and*  
 18                *funded (which may include funding through in-kind*  
 19                *contributions) by one or more of the following:*

20                “(A) *The National Institutes of Health.*

21                “(B) *A cooperative group or center of the*  
 22                *National Institutes of Health.*

23                “(C) *Either of the following if the condi-*  
 24                *tions described in paragraph (2) are met:*

1                   “(i) *The Department of Veterans Af-*  
2                   *fairs.*

3                   “(ii) *The Department of Defense.*

4                   “(2) *CONDITIONS FOR DEPARTMENTS.—The con-*  
5                   *ditions described in this paragraph, for a study or in-*  
6                   *vestigation conducted by a Department, are that the*  
7                   *study or investigation has been reviewed and ap-*  
8                   *proved through a system of peer review that the Sec-*  
9                   *retary determines—*

10                   “(A) *to be comparable to the system of peer*  
11                   *review of studies and investigations used by the*  
12                   *National Institutes of Health, and*

13                   “(B) *assures unbiased review of the highest*  
14                   *scientific standards by qualified individuals who*  
15                   *have no interest in the outcome of the review.*

16                   “(e) *CONSTRUCTION.—Nothing in this section shall be*  
17                   *construed to limit a plan’s coverage with respect to clinical*  
18                   *trials.*

19                   “(f) *PLAN SATISFACTION OF CERTAIN REQUIREMENTS;*  
20                   *RESPONSIBILITIES OF FIDUCIARIES.—*

21                   “(1) *IN GENERAL.—For purposes of this section,*  
22                   *insofar as a group health plan provides benefits in the*  
23                   *form of health insurance coverage through a health in-*  
24                   *surance issuer, the plan shall be treated as meeting*  
25                   *the requirements of this section with respect to such*

1       *benefits and not be considered as failing to meet such*  
2       *requirements because of a failure of the issuer to meet*  
3       *such requirements so long as the plan sponsor or its*  
4       *representatives did not cause such failure by the*  
5       *issuer.*

6               “(2) *CONSTRUCTION.*—*Nothing in this section*  
7       *shall be construed to affect or modify the responsibil-*  
8       *ities of the fiduciaries of a group health plan under*  
9       *part 4 of subtitle B of title I of the Employee Retirement*  
10       *Income Security Act of 1974.*

11       “(g) *STUDY AND REPORT.*—

12               “(1) *STUDY.*—*The Secretary shall study the im-*  
13        *pact on group health plans for covering routine pa-*  
14       *tient care costs for individuals who are entitled to*  
15       *benefits under this section and who are enrolled in an*  
16       *approved cancer clinical trial program.*

17               “(2) *REPORT TO CONGRESS.*—*Not later than*  
18       *January 1, 2005, the Secretary shall submit a report*  
19       *to Congress that contains an assessment of—*

20                       “(A) *any incremental cost to group health*  
21       *plans resulting from the provisions of this sec-*  
22       *tion;*

23                       “(B) *a projection of expenditures to such*  
24       *plans resulting from this section; and*

1                   “(C) any impact on premiums resulting  
2                   from this section.

3   **“SEC. 9830A. PROHIBITING DISCRIMINATION AGAINST PRO-**  
4                   **VIDERS.**

5           “(a) *IN GENERAL.*—A group health plan (other than  
6 a fully insured group health plan) shall not discriminate  
7 with respect to participation or indemnification as to any  
8 provider who is acting within the scope of the provider’s  
9 license or certification under applicable State law, solely  
10 on the basis of such license or certification. This subsection  
11 shall not be construed as requiring the coverage under a  
12 plan of particular benefits or services or to prohibit a plan  
13 from including providers only to the extent necessary to  
14 meet the needs of the plan’s participants and beneficiaries  
15 or from establishing any measure designed to maintain  
16 quality and control costs consistent with the responsibilities  
17 of the plan.

18           “(b) *NO REQUIREMENT FOR ANY WILLING PRO-*  
19 *VIDER.*—Nothing in this section shall be construed as re-  
20 quiring a group health plan that offers network coverage  
21 to include for participation every willing provider or health  
22 professional who meets the terms and conditions of the plan.

23   **“SEC. 9830B. GENERALLY APPLICABLE PROVISION.**

24           *“In the case of a group health plan that provides bene-*  
25 *fits under 2 or more coverage options, the requirements of*



1 *this subchapter shall apply separately with respect to each*  
 2 *coverage option.”.*

3 (b) *DEFINITION.*—*Section 9832(b) of the Internal Rev-*  
 4 *enue Code of 1986 is amended by adding at the end the*  
 5 *following:*

6 “(4) *FULLY INSURED GROUP HEALTH PLAN.*—  
 7 *The term ‘fully insured group health plan’ means a*  
 8 *group health plan where benefits under the plan are*  
 9 *provided pursuant to the terms of an arrangement be-*  
 10 *tween a group health plan and a health insurance*  
 11 *issuer and are guaranteed by the health insurance*  
 12 *issuer under a contract or policy of insurance.”.*

13 (c) *CONFORMING AMENDMENT.*—*Chapter 98 of the In-*  
 14 *ternal Revenue Code of 1986 is amended in the table of sub-*  
 15 *chapters in the item relating to subchapter C, by striking*  
 16 *“Subchapter C” and inserting “Subchapter D”.*

17 **SEC. 103. EFFECTIVE DATE AND RELATED RULES.**

18 (a) *IN GENERAL.*—*The amendments made by this sub-*  
 19 *title shall apply with respect to plan years beginning on*  
 20 *or after January 1 of the second calendar year following*  
 21 *the date of the enactment of this Act. The Secretary shall*  
 22 *issue all regulations necessary to carry out the amendments*  
 23 *made by this section before the effective date thereof.*

24 (b) *LIMITATION ON ENFORCEMENT ACTIONS.*—*No en-*  
 25 *forcement action shall be taken, pursuant to the amend-*

1 *ments made by this subtitle, against a group health plan*  
 2 *with respect to a violation of a requirement imposed by such*  
 3 *amendments before the date of issuance of regulations issued*  
 4 *in connection with such requirement, if the plan has sought*  
 5 *to comply in good faith with such requirement.*

6 ***Subtitle B—Right to Information***  
 7 ***About Plans and Providers***

8 ***SEC. 111. INFORMATION ABOUT PLANS.***

9 *(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT*  
 10 *OF 1974.—*

11 *(1) IN GENERAL.—Subpart B of part 7 of sub-*  
 12 *title B of title I of the Employee Retirement Income*  
 13 *Security Act of 1974 (29 U.S.C. 1185 et seq.) is*  
 14 *amended by adding at the end the following:*

15 ***“SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.***

16 ***“(a) REQUIREMENT.—***

17 *“(1) IN GENERAL.—A group health plan, and a*  
 18 *health insurance issuer that provides coverage in con-*  
 19 *nection with group health insurance coverage, shall,*  
 20 *not later than 12 months after the date of enactment*  
 21 *of this section, and at least annually thereafter, pro-*  
 22 *vide for the disclosure, in a clear and accurate form*  
 23 *to each participant and each beneficiary who does not*  
 24 *reside at the same address as the participant, or upon*  
 25 *request to an individual eligible for coverage under*

1       the plan, of the information described in subsection  
2       (b).

3               “(2) *RULE OF CONSTRUCTION.*—Nothing in this  
4       section shall be construed to prevent a plan or issuer  
5       from entering into any agreement under which the  
6       issuer agrees to assume responsibility for compliance  
7       with the requirements of this section and the plan is  
8       released from liability for such compliance.

9               “(3) *PROVISION OF INFORMATION.*—Information  
10      shall be provided to participants and beneficiaries  
11      under this section at the address maintained by the  
12      plan or issuer with respect to such participants or  
13      beneficiaries.

14              “(b) *REQUIRED INFORMATION.*—The informational  
15      materials to be distributed under this section shall include  
16      for each package option available under a group health plan  
17      the following:

18               “(1) A description of the covered items and serv-  
19      ices under each such plan and any in- and out-of-net-  
20      work features of each such plan, including a sum-  
21      mary description of the specific exclusions from cov-  
22      erage under the plan.

23               “(2) A description of any cost-sharing, including  
24      premiums, deductibles, coinsurance, and copayment  
25      amounts, for which the participant or beneficiary will

1       *be responsible, including any annual or lifetime lim-*  
2       *its on benefits, for each such plan.*

3               *“(3) A description of any optional supplemental*  
4       *benefits offered by each such plan and the terms and*  
5       *conditions (including premiums or cost-sharing) for*  
6       *such supplemental coverage.*

7               *“(4) A description of any restrictions on pay-*  
8       *ments for services furnished to a participant or bene-*  
9       *ficiary by a health care professional that is not a*  
10       *participating professional and the liability of the*  
11       *participant or beneficiary for additional payments*  
12       *for these services.*

13               *“(5) A description of the service area of each*  
14       *such plan, including the provision of any out-of-area*  
15       *coverage.*

16               *“(6) A description of the extent to which partici-*  
17       *pants and beneficiaries may select the primary care*  
18       *provider of their choice, including providers both*  
19       *within the network and outside the network of each*  
20       *such plan (if the plan permits out-of-network serv-*  
21       *ices).*

22               *“(7) A description of the procedures for advance*  
23       *directives and organ donation decisions if the plan*  
24       *maintains such procedures.*

1           “(8) *A description of the requirements and pro-*  
2           *cedures to be used to obtain preauthorization for*  
3           *health services (including telephone numbers and*  
4           *mailing addresses), including referrals for specialty*  
5           *care.*

6           “(9) *A description of the definition of medical*  
7           *necessity used in making coverage determinations by*  
8           *each such plan.*

9           “(10) *A summary of the rules and methods for*  
10          *appealing coverage decisions and filing grievances*  
11          *(including telephone numbers and mailing addresses),*  
12          *as well as other available remedies.*

13          “(11) *A summary description of any provisions*  
14          *for obtaining off-formulary medications if the plan*  
15          *utilizes a defined formulary for providing specific*  
16          *prescription medications.*

17          “(12) *A summary of the rules for access to emer-*  
18          *gency room care. Also, any available educational ma-*  
19          *terial regarding proper use of emergency services.*

20          “(13) *A description of whether or not coverage is*  
21          *provided for experimental treatments, investigational*  
22          *treatments, or clinical trials and the circumstances*  
23          *under which access to such treatments or trials is*  
24          *made available.*

1           “(14) *A description of the specific preventative*  
2           *services covered under the plan if such services are*  
3           *covered.*

4           “(15) *A statement regarding—*

5                   “(A) *the manner in which a participant or*  
6                   *beneficiary may access an obstetrician, gynecologist,*  
7                   *or pediatrician in accordance with sec-*  
8                   *tion 723 or 724; and*

9                   “(B) *the manner in which a participant or*  
10                  *beneficiary obtains continuity of care as pro-*  
11                  *vided for in section 726.*

12           “(16) *A statement that the following informa-*  
13           *tion, and instructions on obtaining such information*  
14           *(including telephone numbers and, if available, Inter-*  
15           *net websites), shall be made available upon request:*

16                   “(A) *The names, addresses, telephone num-*  
17                   *bers, and State licensure status of the plan’s par-*  
18                   *ticipating health care professionals and partici-*  
19                   *pating health care facilities, and, if available,*  
20                   *the education, training, specialty qualifications*  
21                   *or certifications of such professionals.*

22                   “(B) *A summary description of the methods*  
23                   *used for compensating participating health care*  
24                   *professionals, such as capitation, fee-for-service,*  
25                   *salary, or a combination thereof. The require-*

1        *ment of this subparagraph shall not be construed*  
2        *as requiring plans to provide information con-*  
3        *cerning proprietary payment methodology.*

4                *“(C) A summary description of the methods*  
5        *used for compensating health care facilities, in-*  
6        *cluding per diem, fee-for-service, capitation, bun-*  
7        *dled payments, or a combination thereof. The re-*  
8        *quirement of this subparagraph shall not be con-*  
9        *strued as requiring plans to provide information*  
10       *concerning proprietary payment methodology.*

11               *“(D) A summary description of the proce-*  
12       *dures used for utilization review.*

13               *“(E) The list of the specific prescription*  
14       *medications included in the formulary of the*  
15       *plan, if the plan uses a defined formulary.*

16               *“(F) A description of the specific exclusions*  
17       *from coverage under the plan.*

18               *“(G) Any available information related to*  
19       *the availability of translation or interpretation*  
20       *services for non-English speakers and people*  
21       *with communication disabilities, including the*  
22       *availability of audio tapes or information in*  
23       *Braille.*

24               *“(H) Any information that is made public*  
25       *by accrediting organizations in the process of ac-*

1           *creditation if the plan is accredited, or any ad-*  
2           *ditional quality indicators that the plan makes*  
3           *available.*

4           “(c) *MANNER OF DISTRIBUTION.*—*The information de-*  
5           *scribed in this section shall be distributed in an accessible*  
6           *format that is understandable to an average plan partici-*  
7           *pant or beneficiary.*

8           “(d) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*  
9           *tion may be construed to prohibit a group health plan, or*  
10          *health insurance issuer in connection with group health in-*  
11          *surance coverage, from distributing any other additional*  
12          *information determined by the plan or issuer to be impor-*  
13          *tant or necessary in assisting participants and beneficiaries*  
14          *or upon request potential participants and beneficiaries in*  
15          *the selection of a health plan or from providing information*  
16          *under subsection (b)(15) as part of the required informa-*  
17          *tion.*

18          “(e) *CONFORMING REGULATIONS.*—*The Secretary*  
19          *shall issue regulations to coordinate the requirements on*  
20          *group health plans and health insurance issuers under this*  
21          *section with the requirements imposed under part 1, to re-*  
22          *duce duplication with respect to any information that is*  
23          *required to be provided under any such requirements.*

24          “(f) *HEALTH CARE PROFESSIONAL.*—*In this section,*  
25          *the term ‘health care professional’ means a physician (as*



1 *defined in section 1861(r) of the Social Security Act) or*  
 2 *other health care professional if coverage for the profes-*  
 3 *sional's services is provided under the health plan involved*  
 4 *for the services of the professional. Such term includes a*  
 5 *podiatrist, optometrist, chiropractor, psychologist, dentist,*  
 6 *physician assistant, physical or occupational therapist and*  
 7 *therapy assistant, speech-language pathologist, audiologist,*  
 8 *registered or licensed practical nurse (including nurse prac-*  
 9 *titioner, clinical nurse specialist, certified registered nurse*  
 10 *anesthetist, and certified nurse-midwife), licensed certified*  
 11 *social worker, registered respiratory therapist, and certified*  
 12 *respiratory therapy technician.”.*

13 (2) *CONFORMING AMENDMENTS.—*

14 (A) *Section 732(a) of the Employee Retirement*  
 15 *Income Security Act of 1974 (29 U.S.C.*  
 16 *1191a(a)) is amended by striking “section 711,*  
 17 *and inserting “sections 711 and 714”.*

18 (B) *The table of contents in section 1 of the*  
 19 *Employee Retirement Income Security Act of*  
 20 *1974 (29 U.S.C. 1001) is amended by inserting*  
 21 *after the item relating to section 713, the fol-*  
 22 *lowing:*

*“Sec. 714. Health plan comparative information.”.*

23 (b) *INTERNAL REVENUE CODE OF 1986.—Subchapter*  
 24 *B of chapter 100 of the Internal Revenue Code of 1986 is*  
 25 *amended—*

1           (1) *in the table of sections, by inserting after the*  
 2           *item relating to section 9812 the following new item:*

          “Sec. 9813. *Health plan comparative information.*”;

3           *and*

4           (2) *by inserting after section 9812 the following:*

5   **“SEC. 9813. HEALTH PLAN COMPARATIVE INFORMATION.**

6           “(a) *REQUIREMENT.*—

7           “(1) *IN GENERAL.*—A group health plan shall,  
 8           *not later than 12 months after the date of enactment*  
 9           *of this section, and at least annually thereafter, pro-*  
 10          *vide for the disclosure, in a clear and accurate form*  
 11          *to each participant and each beneficiary who does not*  
 12          *reside at the same address as the participant, or upon*  
 13          *request to an individual eligible for coverage under*  
 14          *the plan, of the information described in subsection*  
 15          *(b).*

16          “(2) *RULES OF CONSTRUCTION.*—Nothing in this  
 17          *section shall be construed to prevent a plan from en-*  
 18          *tering into any agreement under which a health in-*  
 19          *surance issuer agrees to assume responsibility for*  
 20          *compliance with the requirements of this section and*  
 21          *the plan is released from liability for such compli-*  
 22          *ance.*

23          “(3) *PROVISION OF INFORMATION.*—Information  
 24          *shall be provided to participants and beneficiaries*  
 25          *under this section at the address maintained by the*

1        *plan with respect to such participants or bene-*  
2        *ficiaries.*

3        “(b) *REQUIRED INFORMATION.—The informational*  
4        *materials to be distributed under this section shall include*  
5        *for each package option available under a group health plan*  
6        *the following:*

7                “(1) *A description of the covered items and serv-*  
8                *ices under each such plan and any in- and out-of-net-*  
9                *work features of each such plan, including a sum-*  
10               *mary description of the specific exclusions from cov-*  
11               *erage under the plan.*

12               “(2) *A description of any cost-sharing, including*  
13               *premiums, deductibles, coinsurance, and copayment*  
14               *amounts, for which the participant or beneficiary will*  
15               *be responsible, including any annual or lifetime lim-*  
16               *its on benefits, for each such plan.*

17               “(3) *A description of any optional supplemental*  
18               *benefits offered by each such plan and the terms and*  
19               *conditions (including premiums or cost-sharing) for*  
20               *such supplemental coverage.*

21               “(4) *A description of any restrictions on pay-*  
22               *ments for services furnished to a participant or bene-*  
23               *ficiary by a health care professional that is not a*  
24               *participating professional and the liability of the*

1     *participant or beneficiary for additional payments*  
2     *for these services.*

3             “(5) *A description of the service area of each*  
4     *such plan, including the provision of any out-of-area*  
5     *coverage.*

6             “(6) *A description of the extent to which partici-*  
7     *pants and beneficiaries may select the primary care*  
8     *provider of their choice, including providers both*  
9     *within the network and outside the network of each*  
10    *such plan (if the plan permits out-of-network serv-*  
11    *ices).*

12            “(7) *A description of the procedures for advance*  
13    *directives and organ donation decisions if the plan*  
14    *maintains such procedures.*

15            “(8) *A description of the requirements and pro-*  
16    *cedures to be used to obtain preauthorization for*  
17    *health services (including telephone numbers and*  
18    *mailing addresses), including referrals for specialty*  
19    *care.*

20            “(9) *A description of the definition of medical*  
21    *necessity used in making coverage determinations by*  
22    *each such plan.*

23            “(10) *A summary of the rules and methods for*  
24    *appealing coverage decisions and filing grievances*

1       *(including telephone numbers and mailing addresses),*  
2       *as well as other available remedies.*

3               *“(11) A summary description of any provisions*  
4       *for obtaining off-formulary medications if the plan*  
5       *utilizes a defined formulary for providing specific*  
6       *prescription medications.*

7               *“(12) A summary of the rules for access to emer-*  
8       *gency room care. Also, any available educational ma-*  
9       *terial regarding proper use of emergency services.*

10              *“(13) A description of whether or not coverage is*  
11       *provided for experimental treatments, investigational*  
12       *treatments, or clinical trials and the circumstances*  
13       *under which access to such treatments or trials is*  
14       *made available.*

15              *“(14) A description of the specific preventative*  
16       *services covered under the plan if such services are*  
17       *covered.*

18              *“(15) A statement regarding—*

19                      *“(A) the manner in which a participant or*  
20       *beneficiary may access an obstetrician, gyne-*  
21       *cologist, or pediatrician in accordance with sec-*  
22       *tion 723 or 724; and*

23                      *“(B) the manner in which a participant or*  
24       *beneficiary obtains continuity of care as pro-*  
25       *vided for in section 726.*

1           “(16) *A statement that the following informa-*  
2           *tion, and instructions on obtaining such information*  
3           *(including telephone numbers and, if available, Inter-*  
4           *net websites), shall be made available upon request:*

5                   “(A) *The names, addresses, telephone num-*  
6                   *bers, and State licensure status of the plan’s par-*  
7                   *ticipating health care professionals and partici-*  
8                   *pating health care facilities, and, if available,*  
9                   *the education, training, specialty qualifications*  
10                  *or certifications of such professionals.*

11                  “(B) *A summary description of the methods*  
12                  *used for compensating participating health care*  
13                  *professionals, such as capitation, fee-for-service,*  
14                  *salary, or a combination thereof. The require-*  
15                  *ment of this subparagraph shall not be construed*  
16                  *as requiring plans to provide information con-*  
17                  *cerning proprietary payment methodology.*

18                  “(C) *A summary description of the methods*  
19                  *used for compensating health care facilities, in-*  
20                  *cluding per diem, fee-for-service, capitation, bun-*  
21                  *dled payments, or a combination thereof. The re-*  
22                  *quirement of this subparagraph shall not be con-*  
23                  *strued as requiring plans to provide information*  
24                  *concerning proprietary payment methodology.*

1                   “(D) *A summary description of the proce-*  
2                   *dures used for utilization review.*

3                   “(E) *The list of the specific prescription*  
4                   *medications included in the formulary of the*  
5                   *plan, if the plan uses a defined formulary.*

6                   “(F) *A description of the specific exclusions*  
7                   *from coverage under the plan.*

8                   “(G) *Any available information related to*  
9                   *the availability of translation or interpretation*  
10                  *services for non-English speakers and people*  
11                  *with communication disabilities, including the*  
12                  *availability of audio tapes or information in*  
13                  *Braille.*

14                  “(H) *Any information that is made public*  
15                  *by accrediting organizations in the process of ac-*  
16                  *creditation if the plan is accredited, or any ad-*  
17                  *ditional quality indicators that the plan makes*  
18                  *available.*

19                  “(c) *MANNER OF DISTRIBUTION.—The information de-*  
20                  *scribed in this section shall be distributed in an accessible*  
21                  *format that is understandable to an average plan partici-*  
22                  *pant or beneficiary.*

23                  “(d) *RULE OF CONSTRUCTION.—Nothing in this sec-*  
24                  *tion may be construed to prohibit a group health plan from*  
25                  *distributing any other additional information determined*

1 *by the plan to be important or necessary in assisting par-*  
 2 *ticipants and beneficiaries or upon request potential par-*  
 3 *ticipants and beneficiaries in the selection of a health plan*  
 4 *or from providing information under subsection (b)(15) as*  
 5 *part of the required information.*

6       “(e) *HEALTH CARE PROFESSIONAL.*—*In this section,*  
 7 *the term ‘health care professional’ means a physician (as*  
 8 *defined in section 1861(r) of the Social Security Act) or*  
 9 *other health care professional if coverage for the profes-*  
 10 *sional’s services is provided under the health plan involved*  
 11 *for the services of the professional. Such term includes a*  
 12 *podiatrist, optometrist, chiropractor, psychologist, dentist,*  
 13 *physician assistant, physical or occupational therapist and*  
 14 *therapy assistant, speech-language pathologist, audiologist,*  
 15 *registered or licensed practical nurse (including nurse prac-*  
 16 *titioner, clinical nurse specialist, certified registered nurse*  
 17 *anesthetist, and certified nurse-midwife), licensed certified*  
 18 *social worker, registered respiratory therapist, and certified*  
 19 *respiratory therapy technician.”.*

20 **SEC. 112. INFORMATION ABOUT PROVIDERS.**

21       (a) *STUDY.*—*The Secretary of Health and Human*  
 22 *Services shall enter into a contract with the Institute of*  
 23 *Medicine for the conduct of a study, and the submission*  
 24 *to the Secretary of a report, that includes—*



1           (1) *an analysis of information concerning health*  
2           *care professionals that is currently available to pa-*  
3           *tients, consumers, States, and professional societies,*  
4           *nationally and on a State-by-State basis, including*  
5           *patient preferences with respect to information about*  
6           *such professionals and their competencies;*

7           (2) *an evaluation of the legal and other barriers*  
8           *to the sharing of information concerning health care*  
9           *professionals; and*

10          (3) *recommendations for the disclosure of infor-*  
11          *mation on health care professionals, including the*  
12          *competencies and professional qualifications of such*  
13          *practitioners, to better facilitate patient choice, qual-*  
14          *ity improvement, and market competition.*

15          (b) *REPORT.*—*Not later than 18 months after the date*  
16          *of enactment of this Act, the Secretary of Health and*  
17          *Human Services shall forward to the appropriate commit-*  
18          *tees of Congress a copy of the report and study conducted*  
19          *under subsection (a).*

1     ***Subtitle C—Right to Hold Health***  
 2                     ***Plans Accountable***

3     ***SEC. 121. AMENDMENT TO EMPLOYEE RETIREMENT IN-***  
 4                     ***COME SECURITY ACT OF 1974.***

5             (a) *IN GENERAL.*—Section 503 of the Employee Re-  
 6     *irement Income Security Act of 1974 (29 U.S.C. 1133) is*  
 7     *amended to read as follows:*

8     ***“SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINA-***  
 9                     ***TION, GRIEVANCES AND APPEALS.***

10            “(a) *CLAIMS PROCEDURE.*—In accordance with regu-  
 11     *lations of the Secretary, every employee benefit plan shall—*

12                     “(1) *provide adequate notice in writing to any*  
 13     *participant or beneficiary whose claim for benefits*  
 14     *under the plan has been denied, setting forth the spe-*  
 15     *cific reasons for such denial, written in a manner cal-*  
 16     *culated to be understood by the participant; and*

17                     “(2) *afford a reasonable opportunity to any par-*  
 18     *ticipant whose claim for benefits has been denied for*  
 19     *a full and fair review by the appropriate named fidu-*  
 20     *ciary of the decision denying the claim.*

21            “(b) *COVERAGE DETERMINATIONS UNDER GROUP*  
 22     *HEALTH PLANS.*—

23                     “(1) *PROCEDURES.*—

24                             “(A) *IN GENERAL.*—A group health plan or  
 25     *health insurance issuer conducting utilization re-*

1           *view shall ensure that procedures are in place*  
2           *for—*

3                   “(i) *making determinations regarding*  
4                   *whether a participant or beneficiary is eli-*  
5                   *gible to receive a payment or coverage for*  
6                   *health services under the plan or coverage*  
7                   *involved and any cost-sharing amount that*  
8                   *the participant or beneficiary is required to*  
9                   *pay with respect to such service;*

10                   “(ii) *notifying a covered participant or*  
11                   *beneficiary (or the authorized representative*  
12                   *of such participant or beneficiary) and the*  
13                   *treating health care professionals involved*  
14                   *regarding determinations made under the*  
15                   *plan or issuer and any additional pay-*  
16                   *ments that the participant or beneficiary*  
17                   *may be required to make with respect to*  
18                   *such service; and*

19                   “(iii) *responding to requests, either*  
20                   *written or oral, for coverage determinations*  
21                   *or for internal appeals from a participant*  
22                   *or beneficiary (or the authorized representa-*  
23                   *tive of such participant or beneficiary) or*  
24                   *the treating health care professional with*

1           *the consent of the participant or bene-*  
2           *ficiary.*

3           “(B) *ORAL REQUESTS.*—*With respect to an*  
4           *oral request described in subparagraph (A)(iii),*  
5           *a group health plan or health insurance issuer*  
6           *may require that the requesting individual pro-*  
7           *vide written evidence of such request.*

8           “(2) *TIMELINE FOR MAKING DETERMINATIONS.*—

9           “(A) *ROUTINE DETERMINATION.*—*A group*  
10          *health plan or a health insurance issuer shall*  
11          *maintain procedures to ensure that prior author-*  
12          *ization determinations concerning the provision*  
13          *of non-emergency items or services are made*  
14          *within 30 days from the date on which the re-*  
15          *quest for a determination is submitted, except*  
16          *that such period may be extended where certain*  
17          *circumstances exist that are determined by the*  
18          *Secretary to be beyond control of the plan or*  
19          *issuer.*

20          “(B) *EXPEDITED DETERMINATION.*—

21          “(i) *IN GENERAL.*—*A prior authoriza-*  
22          *tion determination under this subsection*  
23          *shall be made within 72 hours, in accord-*  
24          *ance with the medical exigencies of the case,*

1           *after a request is received by the plan or*  
2           *issuer under clause (ii) or (iii).*

3           “(ii) *REQUEST BY PARTICIPANT OR*  
4           *BENEFICIARY.—A plan or issuer shall*  
5           *maintain procedures for expediting a prior*  
6           *authorization determination under this sub-*  
7           *section upon the request of a participant or*  
8           *beneficiary if, based on such a request, the*  
9           *plan or issuer determines that the normal*  
10          *time for making such a determination could*  
11          *seriously jeopardize the life or health of the*  
12          *participant or beneficiary.*

13          “(iii) *DOCUMENTATION BY HEALTH*  
14          *CARE PROFESSIONAL.—A plan or issuer*  
15          *shall maintain procedures for expediting a*  
16          *prior authorization determination under*  
17          *this subsection if the request involved indi-*  
18          *cates that the treating health care profes-*  
19          *sional has reasonably documented, based on*  
20          *the medical exigencies, that a determination*  
21          *under the procedures described in subpara-*  
22          *graph (A) could seriously jeopardize the life*  
23          *or health of the participant or beneficiary.*

24          “(C) *CONCURRENT DETERMINATIONS.—A*  
25          *plan or issuer shall maintain procedures to cer-*

1        *tify or deny coverage of an extended stay or ad-*  
2        *ditional services.*

3                “(D) *RETROSPECTIVE DETERMINATION.*—A  
4        *plan or issuer shall maintain procedures to en-*  
5        *sure that, with respect to the retrospective review*  
6        *of a determination made under paragraph (1),*  
7        *the determination shall be made within 30 work-*  
8        *ing days of the date on which the plan or issuer*  
9        *receives necessary information.*

10              “(3) *NOTICE OF DETERMINATIONS.*—

11              “(A) *ROUTINE DETERMINATION.*—With re-  
12        *spect to a coverage determination of a plan or*  
13        *issuer under paragraph (2)(A), the plan or*  
14        *issuer shall issue notice of such determination to*  
15        *the participant or beneficiary (or the authorized*  
16        *representative of the participant or beneficiary)*  
17        *and, consistent with the medical exigencies of the*  
18        *case, to the treating health care professional in-*  
19        *volved not later than 2 working days after the*  
20        *date on which the determination is made.*

21              “(B) *EXPEDITED DETERMINATION.*—With  
22        *respect to a coverage determination of a plan or*  
23        *issuer under paragraph (2)(B), the plan or*  
24        *issuer shall issue notice of such determination to*  
25        *the participant or beneficiary (or the authorized*

1        *representative of the participant or beneficiary),*  
2        *and consistent with the medical exigencies of the*  
3        *case, to the treating health care professional in-*  
4        *volved within the 72 hour period described in*  
5        *paragraph (2)(B).*

6                *“(C) CONCURRENT REVIEWS.—With respect*  
7        *to the determination under a plan or issuer*  
8        *under paragraph (2)(C) to certify or deny cov-*  
9        *erage of an extended stay or additional services,*  
10       *the plan or issuer shall issue notice of such deter-*  
11       *mination to the treating health care professional*  
12       *and to the participant or beneficiary involved*  
13       *(or the authorized representative of the partici-*  
14       *pant or beneficiary) within 1 working day of the*  
15       *determination.*

16               *“(D) RETROSPECTIVE REVIEWS.—With re-*  
17       *spect to the retrospective review under a plan or*  
18       *issuer of a determination made under paragraph*  
19       *(2)(D), the plan or issuer shall issue written no-*  
20       *tice of an approval or disapproval of a deter-*  
21       *mination under this subparagraph to the partic-*  
22       *ipant or beneficiary (or the authorized represent-*  
23       *ative of the participant or beneficiary) and*  
24       *health care provider involved within 5 working*

1       *days of the date on which such determination is*  
2       *made.*

3               “(E) *REQUIREMENTS OF NOTICE OF AD-*  
4       *VERSE COVERAGE DETERMINATIONS.—A written*  
5       *notice of an adverse coverage determination*  
6       *under this subsection, or of an expedited adverse*  
7       *coverage determination under paragraph (2)(B),*  
8       *shall be provided to the participant or bene-*  
9       *ficiary (or the authorized representative of the*  
10       *participant or beneficiary) and treating health*  
11       *care professional (if any) involved and shall*  
12       *include—*

13               “(i) *the reasons for the determination*  
14       *(including the clinical or scientific-evidence*  
15       *based rationale used in making the deter-*  
16       *mination) written in a manner to be under-*  
17       *standable to the average participant or ben-*  
18       *eficiary;*

19               “(ii) *the procedures for obtaining addi-*  
20       *tional information concerning the deter-*  
21       *mination; and*

22               “(iii) *notification of the right to ap-*  
23       *peal the determination and instructions on*  
24       *how to initiate an appeal in accordance*  
25       *with subsection (d).*



1       “(c) *GRIEVANCES.*—A group health plan or a health  
2   insurance issuer shall have written procedures for address-  
3   ing grievances between the plan or issuer offering health  
4   insurance coverage in connection with a group health plan  
5   and a participant or beneficiary. Determinations under  
6   such procedures shall be non-appealable.

7       “(d) *INTERNAL APPEAL OF COVERAGE DETERMINA-*  
8   *TIONS.*—

9       “(1) *RIGHT TO APPEAL.*—

10           “(A) *IN GENERAL.*—A participant or bene-  
11   ficiary (or the authorized representative of the  
12   participant or beneficiary) or the treating health  
13   care professional with the consent of the partici-  
14   pant or beneficiary (or the authorized represent-  
15   ative of the participant or beneficiary), may ap-  
16   peal any adverse coverage determination under  
17   subsection (b) under the procedures described in  
18   this subsection.

19           “(B) *TIME FOR APPEAL.*—A plan or issuer  
20   shall ensure that a participant or beneficiary  
21   has a period of not less than 180 days beginning  
22   on the date of an adverse coverage determination  
23   under subsection (b) in which to appeal such de-  
24   termination under this subsection.

1           “(C) *FAILURE TO ACT.*—*The failure of a*  
2           *plan or issuer to issue a determination under*  
3           *subsection (b) within the applicable timeline es-*  
4           *tablished for such a determination under such*  
5           *subsection shall be treated as an adverse coverage*  
6           *determination for purposes of proceeding to in-*  
7           *ternal review under this subsection.*

8           “(2) *RECORDS.*—*A group health plan and a*  
9           *health insurance issuer shall maintain written*  
10          *records, for at least 6 years, with respect to any ap-*  
11          *peal under this subsection for purposes of internal*  
12          *quality assurance and improvement. Nothing in the*  
13          *preceding sentence shall be construed as preventing a*  
14          *plan and issuer from entering into an agreement*  
15          *under which the issuer agrees to assume responsibility*  
16          *for compliance with the requirements of this section*  
17          *and the plan is released from liability for such com-*  
18          *pliance.*

19          “(3) *ROUTINE DETERMINATIONS.*—*A group*  
20          *health plan or a health insurance issuer shall com-*  
21          *plete the consideration of an appeal of an adverse*  
22          *routine determination under this subsection not later*  
23          *than 30 working days after the date on which a re-*  
24          *quest for such appeal is received.*

25          “(4) *EXPEDITED DETERMINATION.*—

1           “(A) *IN GENERAL.*—An expedited deter-  
2           mination with respect to an appeal under this  
3           subsection shall be made in accordance with the  
4           medical exigencies of the case, but in no case  
5           more than 72 hours after the request for such ap-  
6           peal is received by the plan or issuer under sub-  
7           paragraph (B) or (C).

8           “(B) *REQUEST BY PARTICIPANT OR BENE-*  
9           *FICIARY.*—A plan or issuer shall maintain pro-  
10          cedures for expediting a prior authorization de-  
11          termination under this subsection upon the re-  
12          quest of a participant or beneficiary if, based on  
13          such a request, the plan or issuer determines that  
14          the normal time for making such a determina-  
15          tion could seriously jeopardize the life or health  
16          of the participant or beneficiary.

17          “(C) *DOCUMENTATION BY HEALTH CARE*  
18          *PROFESSIONAL.*—A plan or issuer shall main-  
19          tain procedures for expediting a prior authoriza-  
20          tion determination under this subsection if the  
21          request involved indicates that the treating  
22          health care professional has reasonably docu-  
23          mented, based on the medical exigencies of the  
24          case that a determination under the procedures  
25          described in paragraph (2) could seriously jeop-

1           *ardize the life or health of the participant or*  
2           *beneficiary.*

3           “(5) *CONDUCT OF REVIEW.*—*A review of an ad-*  
4           *verse coverage determination under this subsection*  
5           *shall be conducted by an individual with appropriate*  
6           *expertise who was not directly involved in the initial*  
7           *determination.*

8           “(6) *LACK OF MEDICAL NECESSITY.*—*A review of*  
9           *an appeal under this subsection relating to a deter-*  
10          *mination to deny coverage based on a lack of medical*  
11          *necessity and appropriateness, or based on an experi-*  
12          *mental or investigational treatment, shall be made*  
13          *only by a physician with appropriate expertise, in-*  
14          *cluding age-appropriate expertise, who was not in-*  
15          *volved in the initial determination.*

16          “(7) *NOTICE.*—

17               “(A) *IN GENERAL.*—*Written notice of a de-*  
18               *termination made under an internal review*  
19               *process shall be issued to the participant or bene-*  
20               *ficiary (or the authorized representative of the*  
21               *participant or beneficiary) and the treating*  
22               *health care professional not later than 2 working*  
23               *days after the completion of the review (or with-*  
24               *in the 72-hour period referred to in paragraph*  
25               *(4) if applicable).*

1           “(B) *ADVERSE COVERAGE DETERMINA-*  
2           *TIONS.*—*With respect to an adverse coverage de-*  
3           *termination made under this subsection, the no-*  
4           *tice described in subparagraph (A) shall*  
5           *include—*

6                     “(i) *the reasons for the determination*  
7                     *(including the clinical or scientific-evidence*  
8                     *based rationale used in making the deter-*  
9                     *mination) written in a manner to be under-*  
10                    *standable to the average participant or ben-*  
11                    *eficiary;*

12                   “(ii) *the procedures for obtaining addi-*  
13                    *tional information concerning the deter-*  
14                    *mination; and*

15                   “(iii) *notification of the right to an*  
16                    *independent external review under sub-*  
17                    *section (e) and instructions on how to ini-*  
18                    *tiate such a review.*

19           “(e) *INDEPENDENT EXTERNAL REVIEW.*—

20                   “(1) *ACCESS TO REVIEW.*—

21                   “(A) *IN GENERAL.*—*A group health plan or*  
22                    *a health insurance issuer offering health insur-*  
23                    *ance coverage in connection with a group health*  
24                    *plan shall have written procedures to permit a*  
25                    *participant or beneficiary (or the authorized rep-*

1        *representative of the participant or beneficiary) ac-*  
2        *cess to an independent external review with re-*  
3        *spect to an adverse coverage determination con-*  
4        *cerning a particular item or service (including a*  
5        *circumstance treated as an adverse coverage de-*  
6        *termination under subparagraph (B)) where—*

7                *“(i) the particular item or service*  
8                *involved—*

9                        *“(I)(aa) would be a covered ben-*  
10                      *efit, when medically necessary and ap-*  
11                      *propriate under the terms and condi-*  
12                      *tions of the plan, and the item or serv-*  
13                      *ice has been determined not to be medi-*  
14                      *cally necessary and appropriate under*  
15                      *the internal appeals process required*  
16                      *under subsection (d) or there has been*  
17                      *a failure to issue a coverage determina-*  
18                      *tion as described in subparagraph (B);*  
19                      *and*

20                      *“(bb)(AA) the amount of such*  
21                      *item or service involved exceeds a sig-*  
22                      *nificant financial threshold; or*

23                      *“(BB) there is a significant risk*  
24                      *of placing the life or health of the par-*  
25                      *ticipant or beneficiary in jeopardy; or*

1           “(II) *would be a covered benefit,*  
2           *when not considered experimental or*  
3           *investigational under the terms and*  
4           *conditions of the plan, and the item or*  
5           *service has been determined to be ex-*  
6           *perimental or investigational under the*  
7           *internal appeals process required*  
8           *under subsection (d) or there has been*  
9           *a failure to issue a coverage determina-*  
10          *tion as described in subparagraph (B);*  
11          *and*

12          “(ii) *the participant or beneficiary has*  
13          *completed the internal appeals process*  
14          *under subsection (d) with respect to such de-*  
15          *termination.*

16          “(B) *FAILURE TO ACT.—The failure of a*  
17          *plan or issuer to issue a coverage determination*  
18          *under subsection (d)(6) within the applicable*  
19          *timeline established for such a determination*  
20          *under such subsection shall be treated as an ad-*  
21          *verse coverage determination for purposes of pro-*  
22          *ceeding to independent external review under*  
23          *this subsection.*

24          “(2) *INITIATION OF THE INDEPENDENT EXTER-*  
25          *NAL REVIEW PROCESS.—*

1           “(A) *FILING OF REQUEST.*—A participant  
2           or beneficiary (or the authorized representative  
3           of the participant or beneficiary) who desires to  
4           have an independent external review conducted  
5           under this subsection shall file a written request  
6           for such a review with the plan or issuer in-  
7           volved not later than 30 working days after the  
8           receipt of a final denial of a claim under sub-  
9           section (d). Any such request shall include the  
10          consent of the participant or beneficiary (or the  
11          authorized representative of the participant or  
12          beneficiary) for the release of medical informa-  
13          tion and records to independent external review-  
14          ers regarding the participant or beneficiary.

15          “(B) *TIMEFRAME FOR SELECTION OF AP-*  
16          *PEALS ENTITY.*—Not later than 5 working days  
17          after the receipt of a request under subparagraph  
18          (A), or earlier in accordance with the medical  
19          exigencies of the case, the plan or issuer involved  
20          shall—

21               “(i) select an external appeals entity  
22               under paragraph (3)(A) that shall be re-  
23               sponsible for designating an independent ex-  
24               ternal reviewer under paragraph (3)(B);  
25               and



1           “(ii) provide notice of such selection to  
2           the participant or beneficiary (which shall  
3           include the name and address of the entity).

4           “(C) *PROVISION OF INFORMATION.*—Not  
5           later than 5 working days after the plan or  
6           issuer provides the notice required under sub-  
7           paragraph (B)(ii), or earlier in accordance with  
8           the medical exigencies of the case, the plan,  
9           issuer, participant, beneficiary or physician (of  
10          the participant or beneficiary) involved shall for-  
11          ward necessary information (including, only in  
12          the case of a plan or issuer, medical records, any  
13          relevant review criteria, the clinical rationale  
14          consistent with the terms and conditions of the  
15          contract between the plan or issuer and the par-  
16          ticipant or beneficiary for the coverage denial,  
17          and evidence of the coverage of the participant or  
18          beneficiary) to the qualified external appeals en-  
19          tity designated under paragraph (3)(A).

20          “(D) *FOLLOW-UP WRITTEN NOTIFICA-*  
21          *TION.*—The plan or issuer involved shall send a  
22          follow-up written notification, in a timely man-  
23          ner, to the participant or beneficiary (or the au-  
24          thorized representative of the participant or ben-  
25          eficiary) and the plan administrator, indicating

1           *that an independent external review has been*  
 2           *initiated.*

3           “(3) *CONDUCT OF INDEPENDENT EXTERNAL RE-*  
 4           *VIEW.—*

5                     “(A) *DESIGNATION OF EXTERNAL APPEALS*  
 6           *ENTITY BY PLAN OR ISSUER.—*

7                             “(i) *IN GENERAL.—A plan or issuer*  
 8                             *that receives a request for an independent*  
 9                             *external review under paragraph (2)(A)*  
 10                            *shall designate a qualified entity described*  
 11                            *in clause (ii), in a manner designed to en-*  
 12                            *sure that the entity so designated will make*  
 13                            *a decision in an unbiased manner, to serve*  
 14                            *as the external appeals entity.*

15                           “(ii) *QUALIFIED ENTITIES.—A quali-*  
 16                            *fied entity shall be—*

17                                     “(I) *an independent external re-*  
 18                                     *view entity licensed or credentialed by*  
 19                                     *a State;*

20                                     “(II) *a State agency established*  
 21                                     *for the purpose of conducting inde-*  
 22                                     *pendent external reviews;*

23                                     “(III) *any entity under contract*  
 24                                     *with the Federal Government to pro-*

1 *vide independent external review serv-*  
2 *ices;*

3 “(IV) *any entity accredited as an*  
4 *independent external review entity by*  
5 *an accrediting body recognized by the*  
6 *Secretary for such purpose; or*

7 “(V) *any other entity meeting cri-*  
8 *teria established by the Secretary for*  
9 *purposes of this subparagraph.*

10 “(B) *DESIGNATION OF INDEPENDENT EX-*  
11 *TERNAL REVIEWER BY EXTERNAL APPEALS ENTI-*  
12 *TY.—The external appeals entity designated*  
13 *under subparagraph (A) shall, not later than 30*  
14 *days after the date on which such entity is des-*  
15 *ignated under subparagraph (A), or earlier in*  
16 *accordance with the medical exigencies of the*  
17 *case, designate one or more individuals to serve*  
18 *as independent external reviewers with respect to*  
19 *a request received under paragraph (2)(A). Such*  
20 *reviewers shall be independent medical experts*  
21 *who shall—*

22 “(i) *be appropriately credentialed or*  
23 *licensed in any State to deliver health care*  
24 *services;*

1           “(ii) not have any material, profes-  
2           sional, familial, or financial affiliation  
3           with the case under review, the participant  
4           or beneficiary involved, the treating health  
5           care professional, the institution where the  
6           treatment would take place, or the manufac-  
7           turer of any drug, device, procedure, or  
8           other therapy proposed for the participant  
9           or beneficiary whose treatment is under re-  
10          view;

11          “(iii) have expertise (including age-ap-  
12          propriate expertise) in the diagnosis or  
13          treatment under review and be a physician  
14          of the same specialty, when reasonably  
15          available, as the physician treating the par-  
16          ticipant or beneficiary or recommending or  
17          prescribing the treatment in question;

18          “(iv) receive only reasonable and cus-  
19          tomary compensation from the group health  
20          plan or health insurance issuer in connec-  
21          tion with the independent external review  
22          that is not contingent on the decision ren-  
23          dered by the reviewer; and

24          “(v) not be held liable for decisions re-  
25          garding medical determinations (but may

1                   *be held liable for actions that are arbitrary*  
2                   *and capricious).*

3                   “(4) *STANDARD OF REVIEW.*—

4                   “(A) *IN GENERAL.*—*An independent exter-*  
5                   *nal reviewer shall—*

6                   “(i) *make an independent determina-*  
7                   *tion based on the valid, relevant, scientific*  
8                   *and clinical evidence to determine the med-*  
9                   *ical necessity, appropriateness, experi-*  
10                  *mental or investigational nature of the pro-*  
11                  *posed treatment; and*

12                  “(ii) *take into consideration appro-*  
13                  *priate and available information, including*  
14                  *any evidence-based decision making or clin-*  
15                  *ical practice guidelines used by the group*  
16                  *health plan or health insurance issuer;*  
17                  *timely evidence or information submitted by*  
18                  *the plan, issuer, patient or patient’s physi-*  
19                  *cian; the patient’s medical record; expert*  
20                  *consensus including both generally accepted*  
21                  *medical practice and recognized best prac-*  
22                  *tice; medical literature as defined in section*  
23                  *556(5) of the Federal Food, Drug, and Cos-*  
24                  *metic Act; the following standard reference*  
25                  *compendia: The American Hospital For-*

1            *mulary Service-Drug Information, the*  
2            *American Dental Association Accepted Den-*  
3            *tal Therapeutics, and the United States*  
4            *Pharmacopoeia-Drug Information; and*  
5            *findings, studies, or research conducted by*  
6            *or under the auspices of Federal Govern-*  
7            *ment agencies and nationally recognized*  
8            *Federal research institutes including the*  
9            *Agency for Healthcare Research and Qual-*  
10           *ity, National Institutes of Health, National*  
11           *Academy of Sciences, Health Care Financ-*  
12           *ing Administration, and any national*  
13           *board recognized by the National Institutes*  
14           *of Health for the purposes of evaluating the*  
15           *medical value of health services.*

16           “(B) NOTICE.—The plan or issuer involved  
17           shall ensure that the participant or beneficiary  
18           receives notice, within 30 days after the deter-  
19           mination of the independent medical expert, re-  
20           garding the actions of the plan or issuer with re-  
21           spect to the determination of such expert under  
22           the independent external review.

23           “(5) TIMEFRAME FOR REVIEW.—

24           “(A) IN GENERAL.—The independent exter-  
25           nal reviewer shall complete a review of an ad-

verse coverage determination in accordance with the medical exigencies of the case.

“(B) *EXPEDITED REVIEW.*—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 72 hours after the later of—

“(i) the date on which such reviewer is designated; or

“(ii) the date on which all information necessary to completing such review is received;

if the completion of such review in a period of time in excess of 72 hours would seriously jeopardize the life or health of the participant or beneficiary.

“(C) *LIMITATION.*—Notwithstanding subparagraph (A), and except as provided in subparagraph (B), a review described in subparagraph (A) shall be completed not later than 30 working days after the later of—

“(i) the date on which such reviewer is designated; or

“(ii) the date on which all information necessary to completing such review is received.

1           “(6) *BINDING DETERMINATION AND ACCESS TO*  
2       *CARE.*—

3           “(A) *IN GENERAL.*—*The determination of*  
4       *an independent external reviewer under this sub-*  
5       *section shall be binding upon the plan or issuer*  
6       *if the provisions of this subsection or the proce-*  
7       *dures implemented under such provisions were*  
8       *complied with by the independent external re-*  
9       *viewer.*

10          “(B) *TIMETABLE FOR COMMENCEMENT OF*  
11       *CARE.*—*Where an independent external reviewer*  
12       *determines that the participant or beneficiary is*  
13       *entitled to coverage of the items or services that*  
14       *were the subject of the review, the reviewer shall*  
15       *establish a timeframe, in accordance with the*  
16       *medical exigencies of the case, during which the*  
17       *plan or issuer shall comply with the decision of*  
18       *the reviewer with respect to the coverage of such*  
19       *items or services under the terms and conditions*  
20       *of the plan.*

21          “(C) *FAILURE TO COMPLY.*—*If a plan or*  
22       *issuer fails to comply with the timeframe estab-*  
23       *lished under subparagraph (B) with respect to a*  
24       *participant or beneficiary, where such failure to*  
25       *comply is caused by the plan or issuer, the par-*



1        *ticipant or beneficiary may obtain the items or*  
2        *services involved (in a manner consistent with*  
3        *the determination of the independent external re-*  
4        *viewer) from any provider regardless of whether*  
5        *such provider is a participating provider under*  
6        *the plan or coverage.*

7                *“(D) REIMBURSEMENT.—*

8                *“(i) IN GENERAL.—Where a partici-*  
9        *pant or beneficiary obtains items or services*  
10       *in accordance with subparagraph (C), the*  
11       *plan or issuer involved shall provide for re-*  
12       *imbursement of the costs of such items of*  
13       *services. Such reimbursement shall be made*  
14       *to the treating provider or to the partici-*  
15       *pant or beneficiary (in the case of a partici-*  
16       *pant or beneficiary who pays for the costs*  
17       *of such items or services).*

18               *“(ii) AMOUNT.—The plan or issuer*  
19       *shall fully reimburse a provider, partici-*  
20       *pant or beneficiary under clause (i) for the*  
21       *total costs of the items or services provided*  
22       *(regardless of any plan limitations that*  
23       *may apply to the coverage of such items of*  
24       *services) so long as—*

1                   “(I) the items or services would  
2                   have been covered under the terms of  
3                   the plan or coverage if provided by the  
4                   plan or issuer; and

5                   “(II) the items or services were  
6                   provided in a manner consistent with  
7                   the determination of the independent  
8                   external reviewer.

9                   “(E) *FAILURE TO REIMBURSE.*—Where a  
10                  plan or issuer fails to provide reimbursement to  
11                  a provider, participant or beneficiary in accord-  
12                  ance with this paragraph, the provider, partici-  
13                  pant or beneficiary may commence a civil action  
14                  (or utilize other remedies available under law) to  
15                  recover only the amount of any such reimburse-  
16                  ment that is unpaid and any necessary legal  
17                  costs or expenses (including attorneys’ fees) in-  
18                  curred in recovering such reimbursement.

19                  “(7) *STUDY.*—Not later than 2 years after the  
20                  date of enactment of this section, the General Ac-  
21                  counting Office shall conduct a study of a statistically  
22                  appropriate sample of completed independent external  
23                  reviews. Such study shall include an assessment of the  
24                  process involved during an independent external re-  
25                  view and the basis of decisionmaking by the inde-

1        *pendent external reviewer. The results of such study*  
 2        *shall be submitted to the appropriate committees of*  
 3        *Congress.*

4                “(8) *EFFECT ON CERTAIN PROVISIONS.—Nothing*  
 5        *in this section shall be construed as affecting or modi-*  
 6        *fying section 514 of this Act with respect to a group*  
 7        *health plan.*

8                “(f) *RULE OF CONSTRUCTION.—Nothing in this sec-*  
 9        *tion shall be construed to prohibit a plan administrator or*  
 10        *plan fiduciary or health plan medical director from request-*  
 11        *ing an independent external review by an independent ex-*  
 12        *ternal reviewer without first completing the internal review*  
 13        *process.*

14                “(g) *DEFINITIONS.—In this section:*

15                        “(1) *ADVERSE COVERAGE DETERMINATION.—The*  
 16        *term ‘adverse coverage determination’ means a cov-*  
 17        *erage determination under the plan which results in*  
 18        *a denial of coverage or reimbursement.*

19                        “(2) *COVERAGE DETERMINATION.—The term*  
 20        *‘coverage determination’ means with respect to items*  
 21        *and services for which coverage may be provided*  
 22        *under a health plan, a determination of whether or*  
 23        *not such items and services are covered or reimburs-*  
 24        *able under the coverage and terms of the contract.*

1           “(3) *GRIEVANCE*.—The term ‘grievance’ means  
2           any complaint made by a participant or beneficiary  
3           that does not involve a coverage determination.

4           “(4) *GROUP HEALTH PLAN*.—The term ‘group  
5           health plan’ shall have the meaning given such term  
6           in section 733(a). In applying this paragraph, ex-  
7           cepted benefits described in section 733(c) shall not be  
8           treated as benefits consisting of medical care.

9           “(5) *HEALTH INSURANCE COVERAGE*.—The term  
10          ‘health insurance coverage’ has the meaning given  
11          such term in section 733(b)(1). In applying this  
12          paragraph, excepted benefits described in section  
13          733(c) shall not be treated as benefits consisting of  
14          medical care.

15          “(6) *HEALTH INSURANCE ISSUER*.—The term  
16          ‘health insurance issuer’ has the meaning given such  
17          term in section 733(b)(2).

18          “(7) *PRIOR AUTHORIZATION DETERMINATION*.—  
19          The term ‘prior authorization determination’ means a  
20          coverage determination prior to the provision of the  
21          items and services as a condition of coverage of the  
22          items and services under the coverage.

23          “(8) *TREATING HEALTH CARE PROFESSIONAL*.—  
24          The term ‘treating health care professional’ with re-  
25          spect to a group health plan, health insurance issuer

1       or provider sponsored organization means a physi-  
2       cian (medical doctor or doctor of osteopathy) or other  
3       health care practitioner who is acting within the  
4       scope of his or her State licensure or certification for  
5       the delivery of health care services and who is pri-  
6       marily responsible for delivering those services to the  
7       participant or beneficiary.

8               “(9) *UTILIZATION REVIEW.*—The term ‘utiliza-  
9       tion review’ with respect to a group health plan or  
10      health insurance coverage means a set of formal tech-  
11      niques designed to monitor the use of, or evaluate the  
12      clinical necessity, appropriateness, efficacy, or effi-  
13      ciency of, health care services, procedures, or settings.  
14      Techniques may include ambulatory review, prospec-  
15      tive review, second opinion, certification, concurrent  
16      review, case management, discharge planning or ret-  
17      rospective review.”.

18      (b) *ENFORCEMENT.*—Section 502(c) of the Employee  
19      Retirement Income Security Act of 1974 (29 U.S.C.  
20      1132(c)) is amended by adding at the end the following:

21               “(8) The Secretary may assess a civil penalty against  
22      any plan of up to \$10,000 for the plan’s failure or refusal  
23      to comply with any timeline applicable under section  
24      503(e) or any determination under such section, except that  
25      in any case in which treatment was not commenced by the

1 *plan in accordance with the determination of an inde-*  
 2 *pendent external reviewer, the Secretary shall assess a civil*  
 3 *penalty of \$10,000 against the plan and the plan shall pay*  
 4 *such penalty to the participant or beneficiary involved.”.*

5 (c) *CONFORMING AMENDMENT.—The table of contents*  
 6 *in section 1 of the Employee Retirement Income Security*  
 7 *Act of 1974 is amended by striking the item relating to*  
 8 *section 503 and inserting the following new item:*

*“Sec. 503. Claims procedures, coverage determination, grievances and appeals.”.*

9 (d) *EFFECTIVE DATE.—The amendments made by this*  
 10 *section shall apply with respect to plan years beginning on*  
 11 *or after 1 year after the date of enactment of this Act. The*  
 12 *Secretary shall issue all regulations necessary to carry out*  
 13 *the amendments made by this section before the effective*  
 14 *date thereof.*

## 15 **TITLE II—WOMEN’S HEALTH AND** 16 **CANCER RIGHTS**

### 17 **SEC. 201. WOMEN’S HEALTH AND CANCER RIGHTS.**

18 (a) *SHORT TITLE.—This section may be cited as the*  
 19 *“Women’s Health and Cancer Rights Act of 1999”.*

20 (b) *FINDINGS.—Congress finds that—*

21 (1) *the offering and operation of health plans af-*  
 22 *fect commerce among the States;*

23 (2) *health care providers located in a State serve*  
 24 *patients who reside in the State and patients who re-*  
 25 *side in other States; and*

(3) *in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.*

(c) *AMENDMENTS TO ERISA.*—

(1) *IN GENERAL.*—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 111(a), is further amended by adding at the end the following:

**“SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.**

**“(a) INPATIENT CARE.**—

**“(1) IN GENERAL.**—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consulta-

1        *tion with the patient, to be medically necessary and*  
2        *appropriate following—*

3                *“(A) a mastectomy;*

4                *“(B) a lumpectomy; or*

5                *“(C) a lymph node dissection for the treat-*  
6        *ment of breast cancer.*

7                *“(2) EXCEPTION.—Nothing in this section shall*  
8        *be construed as requiring the provision of inpatient*  
9        *coverage if the attending physician and patient deter-*  
10       *mine that a shorter period of hospital stay is medi-*  
11       *cally appropriate.*

12               *“(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In*  
13       *implementing the requirements of this section, a group*  
14       *health plan, and a health insurance issuer providing health*  
15       *insurance coverage in connection with a group health plan,*  
16       *may not modify the terms and conditions of coverage based*  
17       *on the determination by a participant or beneficiary to re-*  
18       *quest less than the minimum coverage required under sub-*  
19       *section (a).*

20               *“(c) NOTICE.—A group health plan, and a health in-*  
21       *surance issuer providing health insurance coverage in con-*  
22       *nection with a group health plan shall provide notice to*  
23       *each participant and beneficiary under such plan regarding*  
24       *the coverage required by this section in accordance with reg-*  
25       *ulations promulgated by the Secretary. Such notice shall*



1 *be in writing and prominently positioned in any literature*  
2 *or correspondence made available or distributed by the plan*  
3 *or issuer and shall be transmitted—*

4           “(1) *in the next mailing made by the plan or*  
5 *issuer to the participant or beneficiary;*

6           “(2) *as part of any yearly informational packet*  
7 *sent to the participant or beneficiary; or*

8           “(3) *not later than January 1, 2000;*  
9 *whichever is earlier.*

10       “(d) *SECONDARY CONSULTATIONS.—*

11           “(1) *IN GENERAL.—A group health plan, and a*  
12 *health insurance issuer providing health insurance*  
13 *coverage in connection with a group health plan, that*  
14 *provides coverage with respect to medical and sur-*  
15 *gical services provided in relation to the diagnosis*  
16 *and treatment of cancer shall ensure that full coverage*  
17 *is provided for secondary consultations by specialists*  
18 *in the appropriate medical fields (including pathol-*  
19 *ogy, radiology, and oncology) to confirm or refute*  
20 *such diagnosis. Such plan or issuer shall ensure that*  
21 *full coverage is provided for such secondary consulta-*  
22 *tion whether such consultation is based on a positive*  
23 *or negative initial diagnosis. In any case in which*  
24 *the attending physician certifies in writing that serv-*  
25 *ices necessary for such a secondary consultation are*

1     *not sufficiently available from specialists operating*  
2     *under the plan with respect to whose services coverage*  
3     *is otherwise provided under such plan or by such*  
4     *issuer, such plan or issuer shall ensure that coverage*  
5     *is provided with respect to the services necessary for*  
6     *the secondary consultation with any other specialist*  
7     *selected by the attending physician for such purpose*  
8     *at no additional cost to the individual beyond that*  
9     *which the individual would have paid if the specialist*  
10    *was participating in the network of the plan.*

11           “(2) *EXCEPTION.*—*Nothing in paragraph (1)*  
12    *shall be construed as requiring the provision of sec-*  
13    *ondary consultations where the patient determines not*  
14    *to seek such a consultation.*

15           “(e) *PROHIBITION ON PENALTIES OR INCENTIVES.*—  
16    *A group health plan, and a health insurance issuer pro-*  
17    *viding health insurance coverage in connection with a*  
18    *group health plan, may not—*

19           “(1) *penalize or otherwise reduce or limit the re-*  
20    *imbursement of a provider or specialist because the*  
21    *provider or specialist provided care to a participant*  
22    *or beneficiary in accordance with this section;*

23           “(2) *provide financial or other incentives to a*  
24    *physician or specialist to induce the physician or spe-*  
25    *cialist to keep the length of inpatient stays of patients*

1     *following a mastectomy, lumpectomy, or a lymph*  
 2     *node dissection for the treatment of breast cancer*  
 3     *below certain limits or to limit referrals for secondary*  
 4     *consultations; or*

5             *“(3) provide financial or other incentives to a*  
 6     *physician or specialist to induce the physician or spe-*  
 7     *cialist to refrain from referring a participant or bene-*  
 8     *ficiary for a secondary consultation that would other-*  
 9     *wise be covered by the plan or coverage involved*  
 10     *under subsection (d).”.*

11             *(2) CLERICAL AMENDMENT.—The table of con-*  
 12     *tents in section 1 of the Employee Retirement Income*  
 13     *Security Act of 1974 is amended by inserting after*  
 14     *the item relating to section 714 the following new*  
 15     *item:*

*“Sec. 715. Required coverage for minimum hospital stay for mastectomies and  
 lymph node dissections for the treatment of breast cancer and  
 coverage for secondary consultations.”.*

16             *(d) AMENDMENTS TO PHSA RELATING TO THE*  
 17     *GROUP MARKET.—Subpart 2 of part A of title XXVII of*  
 18     *the Public Health Service Act (42 U.S.C. 300gg-4 et seq.)*  
 19     *is amended by adding at the end the following new section:*

1 **“SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 2 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
 3 **DISSECTIONS FOR THE TREATMENT OF**  
 4 **BREAST CANCER AND COVERAGE FOR SEC-**  
 5 **ONDARY CONSULTATIONS.**

6 *“(a) INPATIENT CARE.—*

7 *“(1) IN GENERAL.—A group health plan, and a*  
 8 *health insurance issuer providing health insurance*  
 9 *coverage in connection with a group health plan, that*  
 10 *provides medical and surgical benefits shall ensure*  
 11 *that inpatient coverage with respect to the treatment*  
 12 *of breast cancer is provided for a period of time as*  
 13 *is determined by the attending physician, in consulta-*  
 14 *tion with the patient, to be medically necessary and*  
 15 *appropriate following—*

16 *“(A) a mastectomy;*

17 *“(B) a lumpectomy; or*

18 *“(C) a lymph node dissection for the treat-*  
 19 *ment of breast cancer.*

20 *“(2) EXCEPTION.—Nothing in this section shall*  
 21 *be construed as requiring the provision of inpatient*  
 22 *coverage if the attending physician and patient deter-*  
 23 *mine that a shorter period of hospital stay is medi-*  
 24 *cally appropriate.*

25 *“(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In*  
 26 *implementing the requirements of this section, a group*

1 *health plan, and a health insurance issuer providing health*  
 2 *insurance coverage in connection with a group health plan,*  
 3 *may not modify the terms and conditions of coverage based*  
 4 *on the determination by a participant or beneficiary to re-*  
 5 *quest less than the minimum coverage required under sub-*  
 6 *section (a).*

7       “(c) *NOTICE.*—A group health plan, and a health in-  
 8 *surance issuer providing health insurance coverage in con-*  
 9 *nection with a group health plan shall provide notice to*  
 10 *each participant and beneficiary under such plan regarding*  
 11 *the coverage required by this section in accordance with reg-*  
 12 *ulations promulgated by the Secretary. Such notice shall*  
 13 *be in writing and prominently positioned in any literature*  
 14 *or correspondence made available or distributed by the plan*  
 15 *or issuer and shall be transmitted—*

16               “(1) *in the next mailing made by the plan or*  
 17 *issuer to the participant or beneficiary;*

18               “(2) *as part of any yearly informational packet*  
 19 *sent to the participant or beneficiary; or*

20               “(3) *not later than January 1, 2000;*  
 21 *whichever is earlier.*

22       “(d) *SECONDARY CONSULTATIONS.*—

23               “(1) *IN GENERAL.*—A group health plan, and a  
 24 *health insurance issuer providing health insurance*  
 25 *coverage in connection with a group health plan that*

1 provides coverage with respect to medical and sur-  
2 gical services provided in relation to the diagnosis  
3 and treatment of cancer shall ensure that full coverage  
4 is provided for secondary consultations by specialists  
5 in the appropriate medical fields (including pathol-  
6 ogy, radiology, and oncology) to confirm or refute  
7 such diagnosis. Such plan or issuer shall ensure that  
8 full coverage is provided for such secondary consulta-  
9 tion whether such consultation is based on a positive  
10 or negative initial diagnosis. In any case in which  
11 the attending physician certifies in writing that serv-  
12 ices necessary for such a secondary consultation are  
13 not sufficiently available from specialists operating  
14 under the plan with respect to whose services coverage  
15 is otherwise provided under such plan or by such  
16 issuer, such plan or issuer shall ensure that coverage  
17 is provided with respect to the services necessary for  
18 the secondary consultation with any other specialist  
19 selected by the attending physician for such purpose  
20 at no additional cost to the individual beyond that  
21 which the individual would have paid if the specialist  
22 was participating in the network of the plan.

23 “(2) *EXCEPTION.*—Nothing in paragraph (1)  
24 shall be construed as requiring the provision of sec-

1       ondary consultations where the patient determines not  
2       to seek such a consultation.

3       “(e) *PROHIBITION ON PENALTIES OR INCENTIVES.*—  
4       A group health plan, and a health insurance issuer pro-  
5       viding health insurance coverage in connection with a  
6       group health plan, may not—

7               “(1) penalize or otherwise reduce or limit the re-  
8       imbursement of a provider or specialist because the  
9       provider or specialist provided care to a participant  
10      or beneficiary in accordance with this section;

11              “(2) provide financial or other incentives to a  
12      physician or specialist to induce the physician or spe-  
13      cialist to keep the length of inpatient stays of patients  
14      following a mastectomy, lumpectomy, or a lymph  
15      node dissection for the treatment of breast cancer  
16      below certain limits or to limit referrals for secondary  
17      consultations; or

18              “(3) provide financial or other incentives to a  
19      physician or specialist to induce the physician or spe-  
20      cialist to refrain from referring a participant or bene-  
21      ficiary for a secondary consultation that would other-  
22      wise be covered by the plan or coverage involved  
23      under subsection (d).”.

24      (e) *AMENDMENTS TO PHSA RELATING TO THE INDIV-*  
25      *IDUAL MARKET.*—The first subpart 3 of part B of title

1 *XXVII of the Public Health Service Act (42 U.S.C. 300gg–*  
 2 *51 et seq.) (relating to other requirements) (42 U.S.C.*  
 3 *300gg-51 et seq.) is amended—*

4 *(1) by redesignating such subpart as subpart 2;*  
 5 *and*

6 *(2) by adding at the end the following:*

7 **“SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 8 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
 9 **DISSECTIONS FOR THE TREATMENT OF**  
 10 **BREAST CANCER AND SECONDARY CON-**  
 11 **SULTATIONS.**

12 *“The provisions of section 2707 shall apply to health*  
 13 *insurance coverage offered by a health insurance issuer in*  
 14 *the individual market in the same manner as they apply*  
 15 *to health insurance coverage offered by a health insurance*  
 16 *issuer in connection with a group health plan in the small*  
 17 *or large group market.”.*

18 *(f) AMENDMENTS TO THE IRC.—*

19 *(1) IN GENERAL.—Subchapter B of chapter 100*  
 20 *of the Internal Revenue Code of 1986, as amended by*  
 21 *section 111(b), is further amended by inserting after*  
 22 *section 9813 the following:*



1 **“SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 2 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
 3 **DISSECTIONS FOR THE TREATMENT OF**  
 4 **BREAST CANCER AND COVERAGE FOR SEC-**  
 5 **ONDARY CONSULTATIONS.**

6 “(a) *INPATIENT CARE.*—

7 “(1) *IN GENERAL.*—A group health plan that  
 8 provides medical and surgical benefits shall ensure  
 9 that inpatient coverage with respect to the treatment  
 10 of breast cancer is provided for a period of time as  
 11 is determined by the attending physician, in consulta-  
 12 tion with the patient, to be medically necessary and  
 13 appropriate following—

14 “(A) a mastectomy;

15 “(B) a lumpectomy; or

16 “(C) a lymph node dissection for the treat-  
 17 ment of breast cancer.

18 “(2) *EXCEPTION.*—Nothing in this section shall  
 19 be construed as requiring the provision of inpatient  
 20 coverage if the attending physician and patient deter-  
 21 mine that a shorter period of hospital stay is medi-  
 22 cally appropriate.

23 “(b) *PROHIBITION ON CERTAIN MODIFICATIONS.*—In  
 24 implementing the requirements of this section, a group  
 25 health plan may not modify the terms and conditions of  
 26 coverage based on the determination by a participant or

1 beneficiary to request less than the minimum coverage re-  
2 quired under subsection (a).

3 “(c) NOTICE.—A group health plan shall provide no-  
4 tice to each participant and beneficiary under such plan  
5 regarding the coverage required by this section in accord-  
6 ance with regulations promulgated by the Secretary. Such  
7 notice shall be in writing and prominently positioned in  
8 any literature or correspondence made available or distrib-  
9 uted by the plan and shall be transmitted—

10 “(1) in the next mailing made by the plan to the  
11 participant or beneficiary;

12 “(2) as part of any yearly informational packet  
13 sent to the participant or beneficiary; or

14 “(3) not later than January 1, 2000;  
15 whichever is earlier.

16 “(d) SECONDARY CONSULTATIONS.—

17 “(1) IN GENERAL.—A group health plan that  
18 provides coverage with respect to medical and sur-  
19 gical services provided in relation to the diagnosis  
20 and treatment of cancer shall ensure that full coverage  
21 is provided for secondary consultations by specialists  
22 in the appropriate medical fields (including pathol-  
23 ogy, radiology, and oncology) to confirm or refute  
24 such diagnosis. Such plan or issuer shall ensure that  
25 full coverage is provided for such secondary consulta-

1        *tion whether such consultation is based on a positive*  
2        *or negative initial diagnosis. In any case in which*  
3        *the attending physician certifies in writing that serv-*  
4        *ices necessary for such a secondary consultation are*  
5        *not sufficiently available from specialists operating*  
6        *under the plan with respect to whose services coverage*  
7        *is otherwise provided under such plan or by such*  
8        *issuer, such plan or issuer shall ensure that coverage*  
9        *is provided with respect to the services necessary for*  
10       *the secondary consultation with any other specialist*  
11       *selected by the attending physician for such purpose*  
12       *at no additional cost to the individual beyond that*  
13       *which the individual would have paid if the specialist*  
14       *was participating in the network of the plan.*

15            *“(2) EXCEPTION.—Nothing in paragraph (1)*  
16        *shall be construed as requiring the provision of sec-*  
17        *ondary consultations where the patient determines not*  
18        *to seek such a consultation.*

19            *“(e) PROHIBITION ON PENALTIES.—A group health*  
20        *plan may not—*

21            *“(1) penalize or otherwise reduce or limit the re-*  
22        *imbursement of a provider or specialist because the*  
23        *provider or specialist provided care to a participant*  
24        *or beneficiary in accordance with this section;*

1           “(2) provide financial or other incentives to a  
 2           physician or specialist to induce the physician or spe-  
 3           cialist to keep the length of inpatient stays of patients  
 4           following a mastectomy, lumpectomy, or a lymph  
 5           node dissection for the treatment of breast cancer  
 6           below certain limits or to limit referrals for secondary  
 7           consultations; or

8           “(3) provide financial or other incentives to a  
 9           physician or specialist to induce the physician or spe-  
 10          cialist to refrain from referring a participant or bene-  
 11          ficiary for a secondary consultation that would other-  
 12          wise be covered by the plan involved under subsection  
 13          (d).”.

14           (2) CLERICAL AMENDMENT.—The table of con-  
 15          tents for chapter 100 of such Code is amended by in-  
 16          serting after the item relating to section 9813 the fol-  
 17          lowing new item:

“Sec. 9814. Required coverage for minimum hospital stay for mastectomies and  
 lymph node dissections for the treatment of breast cancer and  
 coverage for secondary consultations.”.

## 18                           **TITLE III—GENETIC** 19                           **INFORMATION AND SERVICES**

### 20   **SEC. 301. SHORT TITLE.**

21           This title may be cited as the “Genetic Information  
 22   Nondiscrimination in Health Insurance Act of 1999”.

1 **SEC. 302. AMENDMENTS TO EMPLOYEE RETIREMENT IN-**  
 2 **COME SECURITY ACT OF 1974.**

3 (a) *PROHIBITION OF HEALTH DISCRIMINATION ON*  
 4 *THE BASIS OF GENETIC INFORMATION OR GENETIC SERV-*  
 5 *ICES.—*

6 (1) *NO ENROLLMENT RESTRICTION FOR GENETIC*  
 7 *SERVICES.—Section 702(a)(1)(F) of the Employee Re-*  
 8 *irement Income Security Act of 1974 (29 U.S.C.*  
 9 *1182(a)(1)(F)) is amended by inserting before the pe-*  
 10 *riod the following: “(including information about a*  
 11 *request for or receipt of genetic services)”.*

12 (2) *NO DISCRIMINATION IN GROUP PREMIUMS*  
 13 *BASED ON PREDICTIVE GENETIC INFORMATION.—Sub-*  
 14 *part B of part 7 of subtitle B of title I of the Em-*  
 15 *ployee Retirement Income Security Act of 1974, as*  
 16 *amended by sections 111(a) and 201, is further*  
 17 *amended by adding at the end the following:*

18 **“SEC. 716. PROHIBITING PREMIUM DISCRIMINATION**  
 19 **AGAINST GROUPS ON THE BASIS OF PRE-**  
 20 **DICTIVE GENETIC INFORMATION.**

21 “A group health plan, or a health insurance issuer of-  
 22 fering group health insurance coverage in connection with  
 23 a group health plan, shall not adjust premium or contribu-  
 24 tion amounts for a group on the basis of predictive genetic  
 25 information concerning any individual (including a de-  
 26 pendent) or family member of the individual (including in-

1 *formation about a request for or receipt of genetic serv-*  
 2 *ices).”.*

3 (3) *CONFORMING AMENDMENTS.*—

4 (A) *IN GENERAL.*—Section 702(b) of the  
 5 *Employee Retirement Income Security Act of*  
 6 *1974 (29 U.S.C. 1182(b)) is amended by adding*  
 7 *at the end the following:*

8 “(3) *REFERENCE TO RELATED PROVISION.*—For  
 9 *a provision prohibiting the adjustment of premium or*  
 10 *contribution amounts for a group under a group*  
 11 *health plan on the basis of predictive genetic informa-*  
 12 *tion (including information about a request for or re-*  
 13 *ceipt of genetic services), see section 716.”.*

14 (B) *TABLE OF CONTENTS.*—The table of  
 15 *contents in section 1 of the Employee Retirement*  
 16 *Income Security Act of 1974, as amended by sec-*  
 17 *tions 111(a) and 201, is further amended by in-*  
 18 *serting after the item relating to section 715 the*  
 19 *following new item:*

“Sec. 716. *Prohibiting premium discrimination against groups on the basis of*  
*predictive genetic information.”.*

20 (b) *LIMITATION ON COLLECTION OF PREDICTIVE GE-*  
 21 *NETIC INFORMATION.*—Section 702 of the *Employee Retire-*  
 22 *ment Income Security Act of 1974 (29 U.S.C. 1182) is*  
 23 *amended by adding at the end the following:*

1       “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
2 *TION.*—

3               “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
4 *PREDICTIVE GENETIC INFORMATION.*—*Except as pro-*  
5 *vided in paragraph (2), a group health plan, or a*  
6 *health insurance issuer offering health insurance cov-*  
7 *erage in connection with a group health plan, shall*  
8 *not request or require predictive genetic information*  
9 *concerning any individual (including a dependent) or*  
10 *family member of the individual (including informa-*  
11 *tion about a request for or receipt of genetic services).*

12               “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
13 *TREATMENT, OR PAYMENT.*—

14               “(A) *IN GENERAL.*—*Notwithstanding para-*  
15 *graph (1), a group health plan, or a health in-*  
16 *surance issuer offering health insurance coverage*  
17 *in connection with a group health plan, that*  
18 *provides health care items and services to an in-*  
19 *dividual or dependent may request (but may not*  
20 *require) that such individual or dependent dis-*  
21 *close, or authorize the collection or disclosure of,*  
22 *predictive genetic information for purposes of di-*  
23 *agnosis, treatment, or payment relating to the*  
24 *provision of health care items and services to*  
25 *such individual or dependent.*

1                   “(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a  
 2                   part of a request under subparagraph (A), the  
 3                   group health plan, or a health insurance issuer  
 4                   offering health insurance coverage in connection  
 5                   with a group health plan, shall provide to the in-  
 6                   dividual or dependent a description of the proce-  
 7                   dures in place to safeguard the confidentiality,  
 8                   as described in subsection (d), of such predictive  
 9                   genetic information.  
 10

11           “(d) CONFIDENTIALITY WITH RESPECT TO PRE-  
 12   DICTIVE GENETIC INFORMATION.—

13                   “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

14                   “(A) PREPARATION OF WRITTEN NOTICE.—  
 15                   A group health plan, or a health insurance  
 16                   issuer offering health insurance coverage in con-  
 17                   nection with a group health plan, shall post or  
 18                   provide, in writing and in a clear and con-  
 19                   spicuous manner, notice of the plan or issuer’s  
 20                   confidentiality practices, that shall include—

21                           “(i) a description of an individual’s  
 22                           rights with respect to predictive genetic in-  
 23                           formation;



1                   “(ii) the procedures established by the  
2                   plan or issuer for the exercise of the individ-  
3                   ual’s rights; and

4                   “(iii) the right to obtain a copy of the  
5                   notice of the confidentiality practices re-  
6                   quired under this subsection.

7                   “(B) *MODEL NOTICE.*—The Secretary, in  
8                   consultation with the National Committee on  
9                   Vital and Health Statistics and the National As-  
10                  sociation of Insurance Commissioners, and after  
11                  notice and opportunity for public comment, shall  
12                  develop and disseminate model notices of con-  
13                  fidentiality practices. Use of the model notice  
14                  shall serve as a defense against claims of receiv-  
15                  ing inappropriate notice.

16                  “(2) *ESTABLISHMENT OF SAFEGUARDS.*—A  
17                  group health plan, or a health insurance issuer offer-  
18                  ing health insurance coverage in connection with a  
19                  group health plan, shall establish and maintain ap-  
20                  propriate administrative, technical, and physical  
21                  safeguards to protect the confidentiality, security, ac-  
22                  curacy, and integrity of predictive genetic informa-  
23                  tion created, received, obtained, maintained, used,  
24                  transmitted, or disposed of by such plan or issuer.”.

1       (c) *DEFINITIONS.*—Section 733(d) of the *Employee Re-*  
 2       *tirement Income Security Act of 1974 (29 U.S.C. 1191b(d))*  
 3       *is amended by adding at the end the following:*

4               “(5) *FAMILY MEMBER.*—The term ‘family mem-  
 5       *ber’ means with respect to an individual—*

6                       “(A) *the spouse of the individual;*

7                       “(B) *a dependent child of the individual,*  
 8                       *including a child who is born to or placed for*  
 9                       *adoption with the individual; and*

10                      “(C) *all other individuals related by blood*  
 11                      *to the individual or the spouse or child described*  
 12                      *in subparagraph (A) or (B).*

13               “(6) *GENETIC INFORMATION.*—The term ‘genetic  
 14       *information’ means information about genes, gene*  
 15       *products, or inherited characteristics that may derive*  
 16       *from an individual or a family member (including*  
 17       *information about a request for or receipt of genetic*  
 18       *services).*

19               “(7) *GENETIC SERVICES.*—The term ‘genetic  
 20       *services’ means health services provided to obtain, as-*  
 21       *sess, or interpret genetic information for diagnostic*  
 22       *and therapeutic purposes, and for genetic education*  
 23       *and counseling.*

24               “(8) *PREDICTIVE GENETIC INFORMATION.*—

1           “(A) *IN GENERAL.*—The term ‘predictive ge-  
2           netic information’ means, in the absence of  
3           symptoms, clinical signs, or a diagnosis of the  
4           condition related to such information—

5                   “(i) information about an individual’s  
6                   genetic tests;

7                   “(ii) information about genetic tests of  
8                   family members of the individual; or

9                   “(iii) information about the occurrence  
10                  of a disease or disorder in family members.

11           “(B) *EXCEPTIONS.*—The term ‘predictive  
12           genetic information’ shall not include—

13                   “(i) information about the sex or age of  
14                   the individual;

15                   “(ii) information derived from phys-  
16                   ical tests, such as the chemical, blood, or  
17                   urine analyses of the individual including  
18                   cholesterol tests; and

19                   “(iii) information about physical  
20                   exams of the individual.

21           “(9) *GENETIC TEST.*—The term ‘genetic test’  
22           means the analysis of human DNA, RNA, chro-  
23           mosomes, proteins, and certain metabolites, including  
24           analysis of genotypes, mutations, phenotypes, or  
25           karyotypes, for the purpose of predicting risk of dis-

12 *SEC. 303. AMENDMENTS TO THE PUBLIC HEALTH SERVICE*  
13 *ACT.*

16 (1) *PROHIBITION OF HEALTH DISCRIMINATION*  
17 *ON THE BASIS OF GENETIC INFORMATION IN THE*  
18 *GROUP MARKET.*—

**HR 2990 EAS**

1                   (B) *NO DISCRIMINATION IN PREMIUMS*  
 2                   *BASED ON PREDICTIVE GENETIC INFORMATION.*—  
 3                   *Subpart 2 of part A of title XXVII of the Public*  
 4                   *Health Service Act, as amended by section 201,*  
 5                   *is further amended by adding at the end the fol-*  
 6                   *lowing new section:*

7   **“SEC. 2708. PROHIBITING PREMIUM DISCRIMINATION**  
 8                   **AGAINST GROUPS ON THE BASIS OF PRE-**  
 9                   **DICTIVE GENETIC INFORMATION IN THE**  
 10                   **GROUP MARKET.**

11           *“A group health plan, or a health insurance issuer of-*  
 12           *fering group health insurance coverage in connection with*  
 13           *a group health plan shall not adjust premium or contribu-*  
 14           *tion amounts for a group on the basis of predictive genetic*  
 15           *information concerning any individual (including a de-*  
 16           *pendent) or family member of the individual (including in-*  
 17           *formation about a request for or receipt of genetic serv-*  
 18           *ices).”.*

19                   (C) *CONFORMING AMENDMENT.*—*Section*  
 20                   *2702(b) of the Public Health Service Act (42*  
 21                   *U.S.C. 300gg–1(b)) is amended by adding at the*  
 22                   *end the following:*

23                   “(3) *REFERENCE TO RELATED PROVISION.*—*For*  
 24                   *a provision prohibiting the adjustment of premium or*  
 25                   *contribution amounts for a group under a group*

1 *health plan on the basis of predictive genetic informa-*  
 2 *tion (including information about a request for or re-*  
 3 *ceipt of genetic services), see section 2708.”.*

4 (D) *LIMITATION ON COLLECTION AND DIS-*  
 5 *CLOSURE OF PREDICTIVE GENETIC INFORMA-*  
 6 *TION.—Section 2702 of the Public Health Service*  
 7 *Act (42 U.S.C. 300gg–1) is amended by adding*  
 8 *at the end the following:*

9 “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
 10 *TION.—*

11 “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
 12 *PREDICTIVE GENETIC INFORMATION.—Except as pro-*  
 13 *vided in paragraph (2), a group health plan, or a*  
 14 *health insurance issuer offering health insurance cov-*  
 15 *erage in connection with a group health plan, shall*  
 16 *not request or require predictive genetic information*  
 17 *concerning any individual (including a dependent) or*  
 18 *a family member of the individual (including infor-*  
 19 *mation about a request for or receipt of genetic serv-*  
 20 *ices).*

21 “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
 22 *TREATMENT, OR PAYMENT.—*

23 “(A) *IN GENERAL.—Notwithstanding para-*  
 24 *graph (1), a group health plan, or a health in-*  
 25 *surance issuer offering health insurance coverage*

1       *in connection with a group health plan, that*  
2       *provides health care items and services to an in-*  
3       *dividual or dependent may request (but may not*  
4       *require) that such individual or dependent dis-*  
5       *close, or authorize the collection or disclosure of,*  
6       *predictive genetic information for purposes of di-*  
7       *agnosis, treatment, or payment relating to the*  
8       *provision of health care items and services to*  
9       *such individual or dependent.*

10           “(B) NOTICE OF CONFIDENTIALITY PRAC-  
11       TICES AND DESCRIPTION OF SAFEGUARDS.—As a  
12       part of a request under subparagraph (A), the  
13       group health plan, or a health insurance issuer  
14       offering health insurance coverage in connection  
15       with a group health plan, shall provide to the in-  
16       dividual or dependent a description of the proce-  
17       dures in place to safeguard the confidentiality,  
18       as described in subsection (d), of such predictive  
19       genetic information.

20           “(d) CONFIDENTIALITY WITH RESPECT TO PRE-  
21       DICTIVE GENETIC INFORMATION.—

22           “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

23           “(A) PREPARATION OF WRITTEN NOTICE.—

24       A group health plan, or a health insurance  
25       issuer offering health insurance coverage in con-

1        *nection with a group health plan, shall post or*  
2        *provide, in writing and in a clear and con-*  
3        *spicuous manner, notice of the plan or issuer's*  
4        *confidentiality practices, that shall include—*

5                *“(i) a description of an individual's*  
6                *rights with respect to predictive genetic in-*  
7                *formation;*

8                *“(ii) the procedures established by the*  
9                *plan or issuer for the exercise of the individ-*  
10               *ual's rights; and*

11               *“(iii) the right to obtain a copy of the*  
12               *notice of the confidentiality practices re-*  
13               *quired under this subsection.*

14               *“(B) MODEL NOTICE.—The Secretary, in*  
15               *consultation with the National Committee on*  
16               *Vital and Health Statistics and the National As-*  
17               *sociation of Insurance Commissioners, and after*  
18               *notice and opportunity for public comment, shall*  
19               *develop and disseminate model notices of con-*  
20               *fidentiality practices. Use of the model notice*  
21               *shall serve as a defense against claims of receiv-*  
22               *ing inappropriate notice.*

23               *“(2) ESTABLISHMENT OF SAFEGUARDS.—A*  
24               *group health plan, or a health insurance issuer offer-*  
25               *ing health insurance coverage in connection with a*



1     *group health plan, shall establish and maintain ap-*  
 2     *propriate administrative, technical, and physical*  
 3     *safeguards to protect the confidentiality, security, ac-*  
 4     *curacy, and integrity of predictive genetic informa-*  
 5     *tion created, received, obtained, maintained, used,*  
 6     *transmitted, or disposed of by such plan or issuer.”.*

7           (2) *DEFINITIONS.*—*Section 2791(d) of the Public*  
 8     *Health Service Act (42 U.S.C. 300gg–91(d)) is*  
 9     *amended by adding at the end the following:*

10           “(15) *FAMILY MEMBER.*—*The term ‘family mem-*  
 11     *ber’ means, with respect to an individual—*

12                   “(A) *the spouse of the individual;*

13                   “(B) *a dependent child of the individual,*  
 14     *including a child who is born to or placed for*  
 15     *adoption with the individual; and*

16                   “(C) *all other individuals related by blood*  
 17     *to the individual or the spouse or child described*  
 18     *in subparagraph (A) or (B).*

19           “(16) *GENETIC INFORMATION.*—*The term ‘ge-*  
 20     *netic information’ means information about genes,*  
 21     *gene products, or inherited characteristics that may*  
 22     *derive from an individual or a family member (in-*  
 23     *cluding information about a request for or receipt of*  
 24     *genetic services).*

1           “(17) *GENETIC SERVICES*.—The term ‘genetic  
2           services’ means health services provided to obtain, as-  
3           sess, or interpret genetic information for diagnostic  
4           and therapeutic purposes, and for genetic education  
5           and counseling.

6           “(18) *PREDICTIVE GENETIC INFORMATION*.—

7                   “(A) *IN GENERAL*.—The term ‘predictive ge-  
8           netic information’ means, in the absence of  
9           symptoms, clinical signs, or a diagnosis of the  
10          condition related to such information—

11                   “(i) information about an individual’s  
12          genetic tests;

13                   “(ii) information about genetic tests of  
14          family members of the individual; or

15                   “(iii) information about the occurrence  
16          of a disease or disorder in family members.

17           “(B) *EXCEPTIONS*.—The term ‘predictive  
18          genetic information’ shall not include—

19                   “(i) information about the sex or age of  
20          the individual;

21                   “(ii) information derived from phys-  
22          ical tests, such as the chemical, blood, or  
23          urine analyses of the individual including  
24          cholesterol tests; and

1 “(iii) information about physical  
2 exams of the individual.

3 “(19) *GENETIC TEST*.—The term ‘genetic test’  
4 means the analysis of human DNA, RNA, chro-  
5 mosomes, proteins, and certain metabolites, including  
6 analysis of genotypes, mutations, phenotypes, or  
7 karyotypes, for the purpose of predicting risk of dis-  
8 ease in asymptomatic or undiagnosed individuals.  
9 Such term does not include physical tests, such as the  
10 chemical, blood, or urine analyses of the individual  
11 including cholesterol tests, and physical exams of the  
12 individual, in order to detect symptoms, clinical  
13 signs, or a diagnosis of disease.”.

14 (b) *AMENDMENT RELATING TO THE INDIVIDUAL MAR-*  
15 *KET*.—Subpart 2 of part B of title XXVII of the Public  
16 Health Service Act, as amended by section 201, is further  
17 amended by adding at the end the following new section:

18 “**SEC. 2754. PROHIBITION OF HEALTH DISCRIMINATION ON**  
19 **THE BASIS OF PREDICTIVE GENETIC INFOR-**  
20 **MATION.**

21 “(a) *PROHIBITION ON PREDICTIVE GENETIC INFORMA-*  
22 *TION AS A CONDITION OF ELIGIBILITY*.—A health insurance  
23 issuer offering health insurance coverage in the individual  
24 market may not use predictive genetic information as a  
25 condition of eligibility of an individual to enroll in indi-

1 *vidual health insurance coverage (including information*  
 2 *about a request for or receipt of genetic services).*

3       “(b) *PROHIBITION ON PREDICTIVE GENETIC INFORMA-*  
 4 *TION IN SETTING PREMIUM RATES.*—A health insurance  
 5 issuer offering health insurance coverage in the individual  
 6 market shall not adjust premium rates for individuals on  
 7 the basis of predictive genetic information concerning such  
 8 an individual (including a dependent) or a family member  
 9 of the individual (including information about a request  
 10 for or receipt of genetic services).

11       “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
 12 *TION.*—

13               “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
 14 *PREDICTIVE GENETIC INFORMATION.*—Except as pro-  
 15 vided in paragraph (2), a health insurance issuer of-  
 16 fering health insurance coverage in the individual  
 17 market shall not request or require predictive genetic  
 18 information concerning any individual (including a  
 19 dependent) or a family member of the individual (in-  
 20 cluding information about a request for or receipt of  
 21 genetic services).

22               “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
 23 *TREATMENT, OR PAYMENT.*—

24               “(A) *IN GENERAL.*—Notwithstanding para-  
 25 graph (1), a health insurance issuer offering

1 *health insurance coverage in the individual mar-*  
 2 *ket that provides health care items and services*  
 3 *to an individual or dependent may request (but*  
 4 *may not require) that such individual or de-*  
 5 *pendent disclose, or authorize the collection or*  
 6 *disclosure of, predictive genetic information for*  
 7 *purposes of diagnosis, treatment, or payment re-*  
 8 *lating to the provision of health care items and*  
 9 *services to such individual or dependent.*

10 “(B) NOTICE OF CONFIDENTIALITY PRAC-  
 11 TICES AND DESCRIPTION OF SAFEGUARDS.—As a  
 12 part of a request under subparagraph (A), the  
 13 health insurance issuer offering health insurance  
 14 coverage in the individual market shall provide  
 15 to the individual or dependent a description of  
 16 the procedures in place to safeguard the con-  
 17 fidentiality, as described in subsection (d), of  
 18 such predictive genetic information.

19 “(d) CONFIDENTIALITY WITH RESPECT TO PRE-  
 20 DICTIVE GENETIC INFORMATION.—

21 “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

22 “(A) PREPARATION OF WRITTEN NOTICE.—

23 *A health insurance issuer offering health insur-*  
 24 *ance coverage in the individual market shall post*  
 25 *or provide, in writing and in a clear and con-*

1        *spicuous manner, notice of the issuer's confiden-*  
2        *tiality practices, that shall include—*

3                *“(i) a description of an individual's*  
4                *rights with respect to predictive genetic in-*  
5                *formation;*

6                *“(ii) the procedures established by the*  
7                *issuer for the exercise of the individual's*  
8                *rights; and*

9                *“(iii) the right to obtain a copy of the*  
10               *notice of the confidentiality practices re-*  
11               *quired under this subsection.*

12               *“(B) MODEL NOTICE.—The Secretary, in*  
13               *consultation with the National Committee on*  
14               *Vital and Health Statistics and the National As-*  
15               *sociation of Insurance Commissioners, and after*  
16               *notice and opportunity for public comment, shall*  
17               *develop and disseminate model notices of con-*  
18               *fidentiality practices. Use of the model notice*  
19               *shall serve as a defense against claims of receiv-*  
20               *ing inappropriate notice.*

21               *“(2) ESTABLISHMENT OF SAFEGUARDS.—A*  
22               *health insurance issuer offering health insurance cov-*  
23               *erage in the individual market shall establish and*  
24               *maintain appropriate administrative, technical, and*  
25               *physical safeguards to protect the confidentiality, se-*

1        *curity, accuracy, and integrity of predictive genetic*  
 2        *information created, received, obtained, maintained,*  
 3        *used, transmitted, or disposed of by such issuer.”.*

4        *(c) EFFECTIVE DATE.—The amendments made by this*  
 5        *section shall apply with respect to—*

6                *(1) group health plans, and health insurance*  
 7        *coverage offered in connection with group health*  
 8        *plans, for plan years beginning after 1 year after the*  
 9        *date of enactment of this Act; and*

10               *(2) health insurance coverage offered, sold,*  
 11        *issued, renewed, in effect, or operated in the indi-*  
 12        *vidual market after 1 year after the date of enactment*  
 13        *of this Act.*

14        **SEC. 304. AMENDMENTS TO THE INTERNAL REVENUE CODE**  
 15                **OF 1986.**

16        *(a) PROHIBITION OF HEALTH DISCRIMINATION ON*  
 17        *THE BASIS OF GENETIC INFORMATION OR GENETIC SERV-*  
 18        *ICES.—*

19               *(1) NO ENROLLMENT RESTRICTION FOR GENETIC*  
 20        *SERVICES.—Section 9802(a)(1)(F) of the Internal*  
 21        *Revenue Code of 1986 is amended by inserting before*  
 22        *the period the following: “(including information*  
 23        *about a request for or receipt of genetic services)”.*

24               *(2) NO DISCRIMINATION IN GROUP PREMIUMS*  
 25        *BASED ON PREDICTIVE GENETIC INFORMATION.—*

1                   (A) *IN GENERAL.*—Subchapter B of chapter  
 2                   100 of the Internal Revenue Code of 1986, as  
 3                   amended by sections 111(b) and 201, is further  
 4                   amended by adding at the end the following:

5   **“SEC. 9815. PROHIBITING PREMIUM DISCRIMINATION**  
 6                   **AGAINST GROUPS ON THE BASIS OF PRE-**  
 7                   **DICTIVE GENETIC INFORMATION.**

8                   “A group health plan shall not adjust premium or con-  
 9                   tribution amounts for a group on the basis of predictive  
 10                  genetic information concerning any individual (including  
 11                  a dependent) or a family member of the individual (includ-  
 12                  ing information about a request for or receipt of genetic  
 13                  services).”.

14                  (B) *CONFORMING AMENDMENT.*—Section  
 15                  9802(b) of the Internal Revenue Code of 1986 is  
 16                  amended by adding at the end the following:

17                  “(3) *REFERENCE TO RELATED PROVISION.*—For  
 18                  a provision prohibiting the adjustment of premium or  
 19                  contribution amounts for a group under a group  
 20                  health plan on the basis of predictive genetic informa-  
 21                  tion (including information about a request for or the  
 22                  receipt of genetic services), see section 9815.”.

23                  (C) *AMENDMENT TO TABLE OF SECTIONS.*—  
 24                  The table of sections for subchapter B of chapter  
 25                  100 of the Internal Revenue Code of 1986, as



1           *amended by sections 111(b) and 201, is further*  
 2           *amended by adding at the end the following:*

*“Sec. 9816. Prohibiting premium discrimination against groups on the basis of predictive genetic information.”.*

3           ***(b) LIMITATION ON COLLECTION OF PREDICTIVE GE-***  
 4 ***NETIC INFORMATION.—Section 9802 of the Internal Rev-***  
 5 ***enue Code of 1986 is amended by adding at the end the***  
 6 ***following:***

7           ***“(d) COLLECTION OF PREDICTIVE GENETIC INFORMA-***  
 8 ***TION.—***

9           ***“(1) LIMITATION ON REQUESTING OR REQUIRING***  
 10 ***PREDICTIVE GENETIC INFORMATION.—Except as pro-***  
 11 ***vided in paragraph (2), a group health plan shall not***  
 12 ***request or require predictive genetic information con-***  
 13 ***cerning any individual (including a dependent) or a***  
 14 ***family member of the individual (including informa-***  
 15 ***tion about a request for or receipt of genetic services).***

16           ***“(2) INFORMATION NEEDED FOR DIAGNOSIS,***  
 17 ***TREATMENT, OR PAYMENT.—***

18           ***“(A) IN GENERAL.—Notwithstanding para-***  
 19 ***graph (1), a group health plan that provides***  
 20 ***health care items and services to an individual***  
 21 ***or dependent may request (but may not require)***  
 22 ***that such individual or dependent disclose, or***  
 23 ***authorize the collection or disclosure of, pre-***  
 24 ***dictive genetic information for purposes of diag-***

1            *nosis, treatment, or payment relating to the pro-*  
 2            *vision of health care items and services to such*  
 3            *individual or dependent.*

4            “(B) NOTICE OF CONFIDENTIALITY PRAC-  
 5            TICES; DESCRIPTION OF SAFEGUARDS.—As a  
 6            part of a request under subparagraph (A), the  
 7            group health plan shall provide to the individual  
 8            or dependent a description of the procedures in  
 9            place to safeguard the confidentiality, as de-  
 10          scribed in subsection (e), of such predictive ge-  
 11          netic information.

12          “(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE  
 13          GENETIC INFORMATION.—

14            “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

15            “(A) PREPARATION OF WRITTEN NOTICE.—  
 16            A group health plan shall post or provide, in  
 17            writing and in a clear and conspicuous manner,  
 18            notice of the plan’s confidentiality practices, that  
 19            shall include—

20            “(i) a description of an individual’s  
 21            rights with respect to predictive genetic in-  
 22            formation;

23            “(ii) the procedures established by the  
 24            plan for the exercise of the individual’s  
 25            rights; and

1                   “(iii) the right to obtain a copy of the  
2                   notice of the confidentiality practices re-  
3                   quired under this subsection.

4                   “(B) *MODEL NOTICE.*—The Secretary, in  
5                   consultation with the National Committee on  
6                   Vital and Health Statistics and the National As-  
7                   sociation of Insurance Commissioners, and after  
8                   notice and opportunity for public comment, shall  
9                   develop and disseminate model notices of con-  
10                  fidentiality practices. Use of the model notice  
11                  shall serve as a defense against claims of receiv-  
12                  ing inappropriate notice.

13                  “(2) *ESTABLISHMENT OF SAFEGUARDS.*—A  
14                  group health plan shall establish and maintain ap-  
15                  propriate administrative, technical, and physical  
16                  safeguards to protect the confidentiality, security, ac-  
17                  curacy, and integrity of predictive genetic informa-  
18                  tion created, received, obtained, maintained, used,  
19                  transmitted, or disposed of by such plan.”.

20                  “(c) *DEFINITIONS.*—Section 9832(d) of the Internal  
21                  Revenue Code of 1986 is amended by adding at the end  
22                  the following:

23                         “(6) *FAMILY MEMBER.*—The term ‘family mem-  
24                         ber’ means, with respect to an individual—

25                                 “(A) the spouse of the individual;

1           “(B) a dependent child of the individual,  
2           including a child who is born to or placed for  
3           adoption with the individual; and

4           “(C) all other individuals related by blood  
5           to the individual or the spouse or child described  
6           in subparagraph (A) or (B).

7           “(7) *GENETIC INFORMATION*.—The term ‘genetic  
8           information’ means information about genes, gene  
9           products, or inherited characteristics that may derive  
10          from an individual or a family member (including  
11          information about a request for or receipt of genetic  
12          services).

13          “(8) *GENETIC SERVICES*.—The term ‘genetic  
14          services’ means health services provided to obtain, as-  
15          sess, or interpret genetic information for diagnostic  
16          and therapeutic purposes, and for genetic education  
17          and counseling.

18          “(9) *PREDICTIVE GENETIC INFORMATION*.—

19                 “(A) *IN GENERAL*.—The term ‘predictive ge-  
20                 netic information’ means, in the absence of  
21                 symptoms, clinical signs, or a diagnosis of the  
22                 condition related to such information—

23                         “(i) information about an individual’s  
24                         genetic tests;

1                   “(ii) information about genetic tests of  
2                   family members of the individual; or

3                   “(iii) information about the occurrence  
4                   of a disease or disorder in family members.

5                   “(B) EXCEPTIONS.—The term ‘predictive  
6                   genetic information’ shall not include—

7                   “(i) information about the sex or age of  
8                   the individual;

9                   “(ii) information derived from phys-  
10                  ical tests, such as the chemical, blood, or  
11                  urine analyses of the individual including  
12                  cholesterol tests; and

13                  “(iii) information about physical  
14                  exams of the individual.

15                  “(10) GENETIC TEST.—The term ‘genetic test’  
16                  means the analysis of human DNA, RNA, chro-  
17                  mosomes, proteins, and certain metabolites, including  
18                  analysis of genotypes, mutations, phenotypes, or  
19                  karyotypes, for the purpose of predicting risk of dis-  
20                  ease in asymptomatic or undiagnosed individuals.  
21                  Such term does not include physical tests, such as the  
22                  chemical, blood, or urine analyses of the individual  
23                  including cholesterol tests, and physical exams of the  
24                  individual, in order to detect symptoms, clinical  
25                  signs, or a diagnosis of disease.”.

1       (d) *EFFECTIVE DATE.*—*Except as provided in this sec-*  
 2 *tion, this section and the amendments made by this section*  
 3 *shall apply with respect to group health plans for plan*  
 4 *years beginning after 1 year after the date of the enactment*  
 5 *of this Act.*

6                   ***TITLE IV—HEALTHCARE***  
 7                   ***RESEARCH AND QUALITY***

8   ***SEC. 401. SHORT TITLE.***

9       *This title may be cited as the “Healthcare Research*  
 10 *and Quality Act of 1999”.*

11   ***SEC. 402. AMENDMENT TO THE PUBLIC HEALTH SERVICE***  
 12                   ***ACT.***

13       *Title IX of the Public Health Service Act (42 U.S.C.*  
 14 *299 et seq.) is amended to read as follows:*

15   ***“TITLE           IX—AGENCY           FOR***  
 16       ***HEALTHCARE RESEARCH AND***  
 17       ***QUALITY***

18       ***“PART A—ESTABLISHMENT AND GENERAL***  
 19                   ***DUTIES***

20   ***“SEC. 901. MISSION AND DUTIES.***

21       ***“(a) IN GENERAL.***—*There is established within the*  
 22 *Public Health Service an agency to be known as the Agency*  
 23 *for Healthcare Research and Quality. In carrying out this*  
 24 *subsection, the Secretary shall redesignate the Agency for*

1 *Health Care Policy and Research as the Agency for*  
2 *Healthcare Research and Quality.*

3       “(b) *MISSION.—The purpose of the Agency is to en-*  
4 *hance the quality, appropriateness, and effectiveness of*  
5 *healthcare services, and access to such services, through the*  
6 *establishment of a broad base of scientific research and*  
7 *through the promotion of improvements in clinical and*  
8 *health system practices, including the prevention of diseases*  
9 *and other health conditions. The Agency shall promote*  
10 *healthcare quality improvement by—*

11               “(1) *conducting and supporting research that de-*  
12 *velops and presents scientific evidence regarding all*  
13 *aspects of healthcare, including—*

14                       “(A) *the development and assessment of*  
15 *methods for enhancing patient participation in*  
16 *their own care and for facilitating shared pa-*  
17 *tient-physician decision-making;*

18                       “(B) *the outcomes, effectiveness, and cost-ef-*  
19 *fectiveness of healthcare practices, including pre-*  
20 *ventive measures and long-term care;*

21                       “(C) *existing and innovative technologies;*

22                       “(D) *the costs and utilization of, and access*  
23 *to healthcare;*

24                       “(E) *the ways in which healthcare services*  
25 *are organized, delivered, and financed and the*

1           *interaction and impact of these factors on the*  
2           *quality of patient care;*

3           “(F) *methods for measuring quality and*  
4           *strategies for improving quality; and*

5           “(G) *ways in which patients, consumers,*  
6           *purchasers, and practitioners acquire new infor-*  
7           *mation about best practices and health benefits,*  
8           *the determinants and impact of their use of this*  
9           *information;*

10          “(2) *synthesizing and disseminating available*  
11          *scientific evidence for use by patients, consumers,*  
12          *practitioners, providers, purchasers, policy makers,*  
13          *and educators; and*

14          “(3) *advancing private and public efforts to im-*  
15          *prove healthcare quality.*

16          “(c) *REQUIREMENTS WITH RESPECT TO RURAL*  
17          *AREAS AND PRIORITY POPULATIONS.—In carrying out sub-*  
18          *section (b), the Director shall undertake and support re-*  
19          *search, demonstration projects, and evaluations with respect*  
20          *to the delivery of health services—*

21                 “(1) *in rural areas (including frontier areas);*

22                 “(2) *for low-income groups, and minority*  
23                 *groups;*

24                 “(3) *for children;*

25                 “(4) *for elderly; and*



1           “(5) for people with special healthcare needs, in-  
 2           cluding disabilities, chronic care and end-of-life  
 3           healthcare.

4           “(d) *APPOINTMENT OF DIRECTOR.*—There shall be at  
 5           the head of the Agency an official to be known as the Direc-  
 6           tor for Healthcare Research and Quality. The Director shall  
 7           be appointed by the Secretary. The Secretary, acting  
 8           through the Director, shall carry out the authorities and  
 9           duties established in this title.

10       **“SEC. 902. GENERAL AUTHORITIES.**

11           “(a) *IN GENERAL.*—In carrying out section 901(b), the  
 12           Director shall support demonstration projects, conduct and  
 13           support research, evaluations, training, research networks,  
 14           multi-disciplinary centers, technical assistance, and the dis-  
 15           semination of information, on healthcare, and on systems  
 16           for the delivery of such care, including activities with re-  
 17           spect to—

18           “(1) the quality, effectiveness, efficiency, appro-  
 19           priateness and value of healthcare services;

20           “(2) quality measurement and improvement;

21           “(3) the outcomes, cost, cost-effectiveness, and use  
 22           of healthcare services and access to such services;

23           “(4) clinical practice, including primary care  
 24           and practice-oriented research;

1           “(5) *healthcare technologies, facilities, and equip-*  
2           *ment;*

3           “(6) *healthcare costs, productivity, organization,*  
4           *and market forces;*

5           “(7) *health promotion and disease prevention,*  
6           *including clinical preventive services;*

7           “(8) *health statistics, surveys, database develop-*  
8           *ment, and epidemiology; and*

9           “(9) *medical liability.*

10          “(b) *HEALTH SERVICES TRAINING GRANTS.—*

11               “(1) *IN GENERAL.—The Director may provide*  
12               *training grants in the field of health services research*  
13               *related to activities authorized under subsection (a),*  
14               *to include pre- and post-doctoral fellowships and*  
15               *training programs, young investigator awards, and*  
16               *other programs and activities as appropriate. In car-*  
17               *rying out this subsection, the Director shall make use*  
18               *of funds made available under section 487 as well as*  
19               *other appropriated funds.*

20               “(2) *REQUIREMENTS.—In developing priorities*  
21               *for the allocation of training funds under this sub-*  
22               *section, the Director shall take into consideration*  
23               *shortages in the number of trained researchers ad-*  
24               *ressing the priority populations.*

1       “(c) *MULTIDISCIPLINARY CENTERS.*—*The Director*  
2 *may provide financial assistance to assist in meeting the*  
3 *costs of planning and establishing new centers, and oper-*  
4 *ating existing and new centers, for multidisciplinary health*  
5 *services research, demonstration projects, evaluations,*  
6 *training, and policy analysis with respect to the matters*  
7 *referred to in subsection (a).*

8       “(d) *RELATION TO CERTAIN AUTHORITIES REGARD-*  
9 *ING SOCIAL SECURITY.*—*Activities authorized in this sec-*  
10 *tion shall be appropriately coordinated with experiments,*  
11 *demonstration projects, and other related activities author-*  
12 *ized by the Social Security Act and the Social Security*  
13 *Amendments of 1967. Activities under subsection (a)(2) of*  
14 *this section that affect the programs under titles XVIII, XIX*  
15 *and XXI of the Social Security Act shall be carried out*  
16 *consistent with section 1142 of such Act.*

17       “(e) *DISCLAIMER.*—*The Agency shall not mandate na-*  
18 *tional standards of clinical practice or quality healthcare*  
19 *standards. Recommendations resulting from projects funded*  
20 *and published by the Agency shall include a corresponding*  
21 *disclaimer.*

22       “(f) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*  
23 *tion shall be construed to imply that the Agency’s role is*  
24 *to mandate a national standard or specific approach to*  
25 *quality measurement and reporting. In research and qual-*

1 *ity improvement activities, the Agency shall consider a wide*  
 2 *range of choices, providers, healthcare delivery systems, and*  
 3 *individual preferences.*

4           **“PART B—HEALTHCARE IMPROVEMENT**  
 5                           **RESEARCH**

6   **“SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RE-**  
 7                           **SEARCH.**

8           “(a) *EVIDENCE RATING SYSTEMS.—In collaboration*  
 9 *with experts from the public and private sector, the Agency*  
 10 *shall identify and disseminate methods or systems that it*  
 11 *uses to assess healthcare research results, particularly meth-*  
 12 *ods or systems that it uses to rate the strength of the sci-*  
 13 *entific evidence behind healthcare practice, recommenda-*  
 14 *tions in the research literature, and technology assessments.*  
 15 *The Agency shall make methods and systems for evidence*  
 16 *rating widely available. Agency publications containing*  
 17 *healthcare recommendations shall indicate the level of sub-*  
 18 *stantiating evidence using such methods or systems.*

19           “(b) *HEALTHCARE IMPROVEMENT RESEARCH CEN-*  
 20 *TERS AND PROVIDER-BASED RESEARCH NETWORKS.—In*  
 21 *order to address the full continuum of care and outcomes*  
 22 *research, to link research to practice improvement, and to*  
 23 *speed the dissemination of research findings to community*  
 24 *practice settings, the Agency shall employ research strate-*  
 25 *gies and mechanisms that will link research directly with*

1 *clinical practice in geographically diverse locations*  
 2 *throughout the United States, including—*

3           “(1) *Healthcare Improvement Research Centers*  
 4           *that combine demonstrated multidisciplinary exper-*  
 5           *tise in outcomes or quality improvement research*  
 6           *with linkages to relevant sites of care;*

7           “(2) *Provider-based Research Networks, includ-*  
 8           *ing plan, facility, or delivery system sites of care (es-*  
 9           *pecially primary care), that can evaluate and pro-*  
 10          *mote quality improvement; and*

11          “(3) *other innovative mechanisms or strategies to*  
 12          *link research with clinical practice.*

13 **“SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE**  
 14                           **ORGANIZATION AND DELIVERY.**

15          “(a) *SUPPORT FOR EFFORTS TO DEVELOP INFORMA-*  
 16          *TION ON QUALITY.—*

17               “(1) *SCIENTIFIC AND TECHNICAL SUPPORT.—In*  
 18               *its role as the principal agency for healthcare research*  
 19               *and quality, the Agency may provide scientific and*  
 20               *technical support for private and public efforts to im-*  
 21               *prove healthcare quality, including the activities of*  
 22               *accrediting organizations.*

23               “(2) *ROLE OF THE AGENCY.—With respect to*  
 24               *paragraph (1), the role of the Agency shall include—*

1           “(A) the identification and assessment of  
2           methods for the evaluation of the health of—

3                   “(i) enrollees in health plans by type of  
4                   plan, provider, and provider arrangements;  
5                   and

6                   “(ii) other populations, including those  
7                   receiving long-term care services;

8           “(B) the ongoing development, testing, and  
9           dissemination of quality measures, including  
10          measures of health and functional outcomes;

11          “(C) the compilation and dissemination of  
12          healthcare quality measures developed in the pri-  
13          vate and public sector;

14          “(D) assistance in the development of im-  
15          proved healthcare information systems;

16          “(E) the development of survey tools for the  
17          purpose of measuring participant and bene-  
18          ficiary assessments of their healthcare; and

19          “(F) identifying and disseminating infor-  
20          mation on mechanisms for the integration of in-  
21          formation on quality into purchaser and con-  
22          sumer decision-making processes.

23          “(b) CENTERS FOR EDUCATION AND RESEARCH ON  
24          THERAPEUTICS.—

1           “(1) *IN GENERAL.*—*The Secretary, acting*  
2           *through the Director and in consultation with the*  
3           *Commissioner of Food and Drugs, shall establish a*  
4           *program for the purpose of making one or more*  
5           *grants for the establishment and operation of one or*  
6           *more centers to carry out the activities specified in*  
7           *paragraph (2).*

8           “(2) *REQUIRED ACTIVITIES.*—*The activities re-*  
9           *ferred to in this paragraph are the following:*

10           “(A) *The conduct of state-of-the-art clinical,*  
11           *laboratory, or health services research for the fol-*  
12           *lowing purposes:*

13                   “(i) *To increase awareness of—*

14                           “(I) *new uses of drugs, biological*  
15                           *products, and devices;*

16                           “(II) *ways to improve the effective*  
17                           *use of drugs, biological products, and*  
18                           *devices; and*

19                           “(III) *risks of new uses and risks*  
20                           *of combinations of drugs and biological*  
21                           *products.*

22                   “(ii) *To provide objective clinical in-*  
23                   *formation to the following individuals and*  
24                   *entities:*

1                   “(I) *Healthcare practitioners and*  
2                   *other providers of healthcare goods or*  
3                   *services.*

4                   “(II) *Pharmacists, pharmacy ben-*  
5                   *efit managers and purchasers.*

6                   “(III) *Health maintenance orga-*  
7                   *nizations and other managed*  
8                   *healthcare organizations.*

9                   “(IV) *Healthcare insurers and*  
10                  *governmental agencies.*

11                  “(V) *Patients and consumers.*

12                  “(iii) *To improve the quality of*  
13                  *healthcare while reducing the cost of*  
14                  *Healthcare through—*

15                       “(I) *an increase in the appro-*  
16                       *priate use of drugs, biological products,*  
17                       *or devices; and*

18                       “(II) *the prevention of adverse ef-*  
19                       *fects of drugs, biological products, and*  
20                       *devices and the consequences of such ef-*  
21                       *fects, such as unnecessary hospitaliza-*  
22                       *tions.*

23                       “(B) *The conduct of research on the com-*  
24                       *parative effectiveness, cost-effectiveness, and safe-*  
25                       *ty of drugs, biological products, and devices.*



1           “(C) *Such other activities as the Secretary*  
2           *determines to be appropriate, except that grant*  
3           *funds may not be used by the Secretary in con-*  
4           *ducting regulatory review of new drugs.*

5           “(c) *REDUCING ERRORS IN MEDICINE.—The Director*  
6           *shall conduct and support research and build private-public*  
7           *partnerships to—*

8           “(1) *identify the causes of preventable healthcare*  
9           *errors and patient injury in healthcare delivery;*

10          “(2) *develop, demonstrate, and evaluate strate-*  
11          *gies for reducing errors and improving patient safety;*  
12          *and*

13          “(3) *promote the implementation of effective*  
14          *strategies throughout the healthcare industry.*

15       **“SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.**

16          “(a) *IN GENERAL.—In carrying out 902(a), the Direc-*  
17          *tor shall—*

18          “(1) *conduct a survey to collect data on a na-*  
19          *tionally representative sample of the population on*  
20          *the cost, use and, for fiscal year 2001 and subsequent*  
21          *fiscal years, quality of healthcare, including the types*  
22          *of healthcare services Americans use, their access to*  
23          *healthcare services, frequency of use, how much is*  
24          *paid for the services used, the source of those pay-*  
25          *ments, the types and costs of private health insurance,*

1       *access, satisfaction, and quality of care for the general*  
2       *population including rural residents and for the pop-*  
3       *ulations identified in section 901(c); and*

4               “(2) *develop databases and tools that provide in-*  
5       *formation to States on the quality, access, and use of*  
6       *healthcare services provided to their residents.*

7       “(b) *QUALITY AND OUTCOMES INFORMATION.—*

8               “(1) *IN GENERAL.—Beginning in fiscal year*  
9       *2001, the Director shall ensure that the survey con-*  
10      *ducted under subsection (a)(1) will—*

11              “(A) *identify determinants of health out-*  
12      *comes and functional status, and their relation-*  
13      *ships to healthcare access and use, determine the*  
14      *ways and extent to which the priority popu-*  
15      *lations enumerated in section 901(c) differ from*  
16      *the general population with respect to such vari-*  
17      *ables, measure changes over time with respect to*  
18      *such variable, and monitor the overall national*  
19      *impact of changes in Federal and State policy*  
20      *on healthcare;*

21              “(B) *provide information on the quality of*  
22      *care and patient outcomes for frequently occur-*  
23      *ring clinical conditions for a nationally rep-*  
24      *resentative sample of the population including*  
25      *rural residents; and*

1           “(C) provide reliable national estimates for  
2           children and persons with special healthcare  
3           needs through the use of supplements or periodic  
4           expansions of the survey.

5           *In expanding the Medical Expenditure Panel Survey,*  
6           *as in existence on the date of enactment of this title,*  
7           *in fiscal year 2001 to collect information on the qual-*  
8           *ity of care, the Director shall take into account any*  
9           *outcomes measurements generally collected by private*  
10          *sector accreditation organizations.*

11          “(2) ANNUAL REPORT.—Beginning in fiscal year  
12          2003, the Secretary, acting through the Director, shall  
13          submit to Congress an annual report on national  
14          trends in the quality of healthcare provided to the  
15          American people.

16          **“SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IM-**  
17   **PROVEMENT.**

18          “(a) IN GENERAL.—In order to foster a range of inno-  
19          vative approaches to the management and communication  
20          of health information, the Agency shall support research,  
21          evaluations and initiatives to advance—

22                 “(1) the use of information systems for the study  
23                 of healthcare quality, including the generation of both  
24                 individual provider and plan-level comparative per-  
25                 formance data;

1           “(2) training for healthcare practitioners and re-  
2           searchers in the use of information systems;

3           “(3) the creation of effective linkages between  
4           various sources of health information, including the  
5           development of information networks;

6           “(4) the delivery and coordination of evidence-  
7           based healthcare services, including the use of real-  
8           time healthcare decision-support programs;

9           “(5) the utility and comparability of health in-  
10          formation data and medical vocabularies by address-  
11          ing issues related to the content, structure, definitions  
12          and coding of such information and data in consulta-  
13          tion with appropriate Federal, State and private en-  
14          tities;

15          “(6) the use of computer-based health records in  
16          all settings for the development of personal health  
17          records for individual health assessment and mainte-  
18          nance, and for monitoring public health and outcomes  
19          of care within populations; and

20          “(7) the protection of individually identifiable  
21          information in health services research and healthcare  
22          quality improvement.

23          “(b) DEMONSTRATION.—The Agency shall support  
24          demonstrations into the use of new information tools aimed

1 *at improving shared decision-making between patients and*  
 2 *their care-givers.*

3 **“SEC. 915. RESEARCH SUPPORTING PRIMARY CARE AND AC-**  
 4 **CESS IN UNDERSERVED AREAS.**

5 *“(a) PREVENTIVE SERVICES TASK FORCE.—*

6 *“(1) ESTABLISHMENT AND PURPOSE.—The Di-*  
 7 *rector may periodically convene a Preventive Services*  
 8 *Task Force to be composed of individuals with appro-*  
 9 *priate expertise. Such a task force shall review the*  
 10 *scientific evidence related to the effectiveness, appro-*  
 11 *priateness, and cost-effectiveness of clinical preventive*  
 12 *services for the purpose of developing recommenda-*  
 13 *tions for the healthcare community, and updating*  
 14 *previous clinical preventive recommendations.*

15 *“(2) ROLE OF AGENCY.—The Agency shall pro-*  
 16 *vide ongoing administrative, research, and technical*  
 17 *support for the operations of the Preventive Services*  
 18 *Task Force, including coordinating and supporting*  
 19 *the dissemination of the recommendations of the Task*  
 20 *Force.*

21 *“(3) OPERATION.—In carrying out its respon-*  
 22 *sibilities under paragraph (1), the Task Force is not*  
 23 *subject to the provisions of Appendix 2 of title 5,*  
 24 *United States Code.*

25 *“(b) PRIMARY CARE RESEARCH.—*

1           “(1) *IN GENERAL.*—*There is established within*  
2           *the Agency a Center for Primary Care Research (re-*  
3           *ferred to in this subsection as the ‘Center’)* *that shall*  
4           *serve as the principal source of funding for primary*  
5           *care practice research in the Department of Health*  
6           *and Human Services. For purposes of this paragraph,*  
7           *primary care research focuses on the first contact*  
8           *when illness or health concerns arise, the diagnosis,*  
9           *treatment or referral to specialty care, preventive*  
10           *care, and the relationship between the clinician and*  
11           *the patient in the context of the family and commu-*  
12           *nity.*

13           “(2) *RESEARCH.*—*In carrying out this section,*  
14           *the Center shall conduct and support research*  
15           *concerning—*

16                   “(A) *the nature and characteristics of pri-*  
17                   *mary care practice;*

18                   “(B) *the management of commonly occur-*  
19                   *ring clinical problems;*

20                   “(C) *the management of undifferentiated*  
21                   *clinical problems; and*

22                   “(D) *the continuity and coordination of*  
23                   *health services.*

1   **“SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVA-**  
2                                   **TION.**

3           “(a) *IN GENERAL.*—*The Director shall promote inno-*  
4   *vation in evidence-based clinical practice and healthcare*  
5   *technologies by—*

6                   “(1) *conducting and supporting research on the*  
7           *development, diffusion, and use of healthcare tech-*  
8           *nology;*

9                   “(2) *developing, evaluating, and disseminating*  
10   *methodologies for assessments of healthcare practices*  
11   *and healthcare technologies;*

12                   “(3) *conducting intramural and supporting ex-*  
13   *tramural assessments of existing and new healthcare*  
14   *practices and technologies;*

15                   “(4) *promoting education, training, and pro-*  
16   *viding technical assistance in the use of healthcare*  
17   *practice and healthcare technology assessment meth-*  
18   *odologies and results; and*

19                   “(5) *working with the National Library of Medi-*  
20   *cine and the public and private sector to develop an*  
21   *electronic clearinghouse of currently available assess-*  
22   *ments and those in progress.*

23           “(b) *SPECIFICATION OF PROCESS.*—

24                   “(1) *IN GENERAL.*—*Not later than December 31,*  
25   *2000, the Director shall develop and publish a de-*  
26   *scription of the methodology used by the Agency and*

1 *its contractors in conducting practice and technology*  
2 *assessment.*

3 “(2) *CONSULTATIONS.*—*In carrying out this sub-*  
4 *section, the Director shall cooperate and consult with*  
5 *the Assistant Secretary for Health, the Administrator*  
6 *of the Health Care Financing Administration, the Di-*  
7 *rector of the National Institutes of Health, the Com-*  
8 *missioner of Food and Drugs, and the heads of any*  
9 *other interested Federal department or agency, and*  
10 *shall seek input, where appropriate, from professional*  
11 *societies and other private and public entities.*

12 “(3) *METHODOLOGY.*—*The Director, in devel-*  
13 *oping assessment methodology, shall consider—*

14 “(A) *safety, efficacy, and effectiveness;*

15 “(B) *legal, social, and ethical implications;*

16 “(C) *costs, benefits, and cost-effectiveness;*

17 “(D) *comparisons to alternate technologies*  
18 *and practices; and*

19 “(E) *requirements of Food and Drug Ad-*  
20 *ministration approval to avoid duplication.*

21 “(c) *SPECIFIC ASSESSMENTS.*—

22 “(1) *IN GENERAL.*—*The Director shall conduct*  
23 *or support specific assessments of healthcare tech-*  
24 *nologies and practices.*



1           “(2) *REQUESTS FOR ASSESSMENTS.*—*The Direc-*  
2           *tor is authorized to conduct or support assessments,*  
3           *on a reimbursable basis, for the Health Care Financ-*  
4           *ing Administration, the Department of Defense, the*  
5           *Department of Veterans Affairs, the Office of Per-*  
6           *sonnel Management, and other public or private enti-*  
7           *ties.*

8           “(3) *GRANTS AND CONTRACTS.*—*In addition to*  
9           *conducting assessments, the Director may make*  
10          *grants to, or enter into cooperative agreements or con-*  
11          *tracts with, entities described in paragraph (4) for*  
12          *the purpose of conducting assessments of experi-*  
13          *mental, emerging, existing, or potentially outmoded*  
14          *healthcare technologies, and for related activities.*

15          “(4) *ELIGIBLE ENTITIES.*—*An entity described*  
16          *in this paragraph is an entity that is determined to*  
17          *be appropriate by the Director, including academic*  
18          *medical centers, research institutions and organiza-*  
19          *tions, professional organizations, third party payers,*  
20          *governmental agencies, and consortia of appropriate*  
21          *research entities established for the purpose of con-*  
22          *ducting technology assessments.*

23   **“SEC. 917. COORDINATION OF FEDERAL GOVERNMENT**  
24                   **QUALITY IMPROVEMENT EFFORTS.**

25          “(a) *REQUIREMENT.*—

1           “(1) *IN GENERAL.*—To avoid duplication and  
2       ensure that Federal resources are used efficiently and  
3       effectively, the Secretary, acting through the Director,  
4       shall coordinate all research, evaluations, and dem-  
5       onstrations related to health services research, quality  
6       measurement and quality improvement activities un-  
7       dertaken and supported by the Federal Government.

8           “(2) *SPECIFIC ACTIVITIES.*—The Director, in col-  
9       laboration with the appropriate Federal officials rep-  
10      resenting all concerned executive agencies and depart-  
11      ments, shall develop and manage a process to—

12           “(A) improve interagency coordination, pri-  
13      ority setting, and the use and sharing of research  
14      findings and data pertaining to Federal quality  
15      improvement programs, technology assessment,  
16      and health services research;

17           “(B) strengthen the research information  
18      infrastructure, including databases, pertaining  
19      to Federal health services research and healthcare  
20      quality improvement initiatives;

21           “(C) set specific goals for participating  
22      agencies and departments to further health serv-  
23      ices research and healthcare quality improve-  
24      ment; and

1                   “(D) strengthen the management of Federal  
2                   healthcare quality improvement programs.

3                   “(b) *STUDY BY THE INSTITUTE OF MEDICINE.*—

4                   “(1) *IN GENERAL.*—To provide Congress, the De-  
5                   partment of Health and Human Services, and other  
6                   relevant departments with an independent, external  
7                   review of their quality oversight, quality improvement  
8                   and quality research programs, the Secretary shall  
9                   enter into a contract with the Institute of Medicine—

10                  “(A) to describe and evaluate current qual-  
11                  ity improvement, quality research and quality  
12                  monitoring processes through—

13                  “(i) an overview of pertinent health  
14                  services research activities and quality im-  
15                  provement efforts conducted by all Federal  
16                  programs, with particular attention paid to  
17                  those under titles XVIII, XIX, and XXI of  
18                  the Social Security Act; and

19                  “(ii) a summary of the partnerships  
20                  that the Department of Health and Human  
21                  Services has pursued with private accredi-  
22                  tation, quality measurement and improve-  
23                  ment organizations; and

24                  “(B) to identify options and make rec-  
25                  ommendations to improve the efficiency and ef-

fectiveness of quality improvement programs  
through—

“(i) the improved coordination of activities across the medicare, medicaid and child health insurance programs under titles XVIII, XIX and XXI of the Social Security Act and health services research programs;

“(ii) the strengthening of patient choice and participation by incorporating state-of-the-art quality monitoring tools and making information on quality available; and

“(iii) the enhancement of the most effective programs, consolidation as appropriate, and elimination of duplicative activities within various federal agencies.

“(2) REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine for the preparation—

“(i) not later than 12 months after the date of enactment of this title, of a report providing an overview of the quality improvement programs of the Department of Health and Human Services for the medicare, medicaid, and CHIP programs under

1                   *titles XVIII, XIX, and XXI of the Social Se-*  
 2                   *curity Act; and*

3                   “(ii) *not later than 24 months after the*  
 4                   *date of enactment of this title, of a final re-*  
 5                   *port containing recommendations.*

6                   “(B) *REPORTS.*—*The Secretary shall sub-*  
 7                   *mit the reports described in subparagraph (A) to*  
 8                   *the Committee on Finance and the Committee on*  
 9                   *Health, Education, Labor, and Pensions of the*  
 10                   *Senate and the Committee on Ways and Means*  
 11                   *and the Committee on Commerce of the House of*  
 12                   *Representatives.*

13                   **“PART C—GENERAL PROVISIONS**

14                   **“SEC. 921. ADVISORY COUNCIL FOR HEALTHCARE RE-**  
 15                   **SEARCH AND QUALITY.**

16                   “(a) *ESTABLISHMENT.*—*There is established an advi-*  
 17                   *sory council to be known as the Advisory Council for*  
 18                   *Healthcare Research and Quality.*

19                   “(b) *DUTIES.*—

20                   “(1) *IN GENERAL.*—*The Advisory Council shall*  
 21                   *advise the Secretary and the Director with respect to*  
 22                   *activities proposed or undertaken to carry out the*  
 23                   *purpose of the Agency under section 901(b).*

24                   “(2) *CERTAIN RECOMMENDATIONS.*—*Activities of*  
 25                   *the Advisory Council under paragraph (1) shall in-*

1 *clude making recommendations to the Director*  
2 *regarding—*

3 *“(A) priorities regarding healthcare re-*  
4 *search, especially studies related to quality, out-*  
5 *comes, cost and the utilization of, and access to,*  
6 *healthcare services;*

7 *“(B) the field of healthcare research and re-*  
8 *lated disciplines, especially issues related to*  
9 *training needs, and dissemination of informa-*  
10 *tion pertaining to healthcare quality; and*

11 *“(C) the appropriate role of the Agency in*  
12 *each of these areas in light of private sector ac-*  
13 *tivity and identification of opportunities for*  
14 *public-private sector partnerships.*

15 *“(c) MEMBERSHIP.—*

16 *“(1) IN GENERAL.—The Advisory Council shall,*  
17 *in accordance with this subsection, be composed of ap-*  
18 *pointed members and ex officio members. All members*  
19 *of the Advisory Council shall be voting members other*  
20 *than the individuals designated under paragraph*  
21 *(3)(B) as ex officio members.*

22 *“(2) APPOINTED MEMBERS.—The Secretary shall*  
23 *appoint to the Advisory Council 21 appropriately*  
24 *qualified individuals. At least 17 members of the Ad-*  
25 *visory Council shall be representatives of the public*

1       *who are not officers or employees of the United States.*

2       *The Secretary shall ensure that the appointed mem-*  
3       *bers of the Council, as a group, are representative of*  
4       *professions and entities concerned with, or affected by,*  
5       *activities under this title and under section 1142 of*  
6       *the Social Security Act. Of such members—*

7               “(A) 4 shall be individuals distinguished in  
8               *the conduct of research, demonstration projects,*  
9               *and evaluations with respect to healthcare;*

10              “(B) 4 shall be individuals distinguished in  
11              *the practice of medicine of which at least 1 shall*  
12              *be a primary care practitioner;*

13              “(C) 3 shall be individuals distinguished in  
14              *the other health professions;*

15              “(D) 4 shall be individuals either rep-  
16              *resenting the private healthcare sector, including*  
17              *health plans, providers, and purchasers or indi-*  
18              *viduals distinguished as administrators of*  
19              *healthcare delivery systems;*

20              “(E) 4 shall be individuals distinguished in  
21              *the fields of healthcare quality improvement, eco-*  
22              *nomics, information systems, law, ethics, busi-*  
23              *ness, or public policy, including at least 1 indi-*  
24              *vidual specializing in rural aspects in 1 or more*  
25              *of these fields; and*

1                   “(F) 2 shall be individuals representing the  
2                   interests of patients and consumers of healthcare.

3                   “(3) *EX OFFICIO MEMBERS.*—The Secretary shall  
4                   designate as *ex officio* members of the Advisory  
5                   Council—

6                   “(A) the Assistant Secretary for Health, the  
7                   Director of the National Institutes of Health, the  
8                   Director of the Centers for Disease Control and  
9                   Prevention, the Administrator of the Health Care  
10                  Financing Administration, the Assistant Sec-  
11                  retary of Defense (Health Affairs), and the  
12                  Under Secretary for Health of the Department of  
13                  Veterans Affairs; and

14                  “(B) such other Federal officials as the Sec-  
15                  retary may consider appropriate.

16                  “(d) *TERMS.*—Members of the Advisory Council ap-  
17                  pointed under subsection (c)(2) shall serve for a term of 3  
18                  years. A member of the Council appointed under such sub-  
19                  section may continue to serve after the expiration of the  
20                  term of the members until a successor is appointed.

21                  “(e) *VACANCIES.*—If a member of the Advisory Council  
22                  appointed under subsection (c)(2) does not serve the full  
23                  term applicable under subsection (d), the individual ap-  
24                  pointed to fill the resulting vacancy shall be appointed for



1 *the remainder of the term of the predecessor of the indi-*  
2 *vidual.*

3       “(f) *CHAIR.*—*The Director shall, from among the*  
4 *members of the Advisory Council appointed under sub-*  
5 *section (c)(2), designate an individual to serve as the chair*  
6 *of the Advisory Council.*

7       “(g) *MEETINGS.*—*The Advisory Council shall meet not*  
8 *less than once during each discrete 4-month period and*  
9 *shall otherwise meet at the call of the Director or the chair.*

10       “(h) *COMPENSATION AND REIMBURSEMENT OF EX-*  
11 *PENSES.*—

12               “(1) *APPOINTED MEMBERS.*—*Members of the Ad-*  
13 *visory Council appointed under subsection (c)(2) shall*  
14 *receive compensation for each day (including travel*  
15 *time) engaged in carrying out the duties of the Advi-*  
16 *sory Council unless declined by the member. Such*  
17 *compensation may not be in an amount in excess of*  
18 *the daily equivalent of the annual rate of basic pay*  
19 *prescribed for level IV of the Executive Schedule*  
20 *under section 5315 of title 5, United States Code, for*  
21 *each day during which such member is engaged in the*  
22 *performance of the duties of the Advisory Council.*

23               “(2) *EX OFFICIO MEMBERS.*—*Officials des-*  
24 *ignated under subsection (c)(3) as ex officio members*  
25 *of the Advisory Council may not receive compensation*

1       *for service on the Advisory Council in addition to the*  
 2       *compensation otherwise received for duties carried out*  
 3       *as officers of the United States.*

4       “(i) *STAFF.*—*The Director shall provide to the Advi-*  
 5       *sory Council such staff, information, and other assistance*  
 6       *as may be necessary to carry out the duties of the Council.*

7       **“SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND**  
 8       **CONTRACTS.**

9       “(a) *REQUIREMENT OF REVIEW.*—

10           “(1) *IN GENERAL.*—*Appropriate technical and*  
 11       *scientific peer review shall be conducted with respect*  
 12       *to each application for a grant, cooperative agree-*  
 13       *ment, or contract under this title.*

14           “(2) *REPORTS TO DIRECTOR.*—*Each peer review*  
 15       *group to which an application is submitted pursuant*  
 16       *to paragraph (1) shall report its finding and rec-*  
 17       *ommendations respecting the application to the Direc-*  
 18       *tor in such form and in such manner as the Director*  
 19       *shall require.*

20       “(b) *APPROVAL AS PRECONDITION OF AWARDS.*—*The*  
 21       *Director may not approve an application described in sub-*  
 22       *section (a)(1) unless the application is recommended for ap-*  
 23       *proval by a peer review group established under subsection*  
 24       *(c).*

25       “(c) *ESTABLISHMENT OF PEER REVIEW GROUPS.*—

1           “(1) *IN GENERAL.*—*The Director shall establish*  
2           *such technical and scientific peer review groups as*  
3           *may be necessary to carry out this section. Such*  
4           *groups shall be established without regard to the pro-*  
5           *visions of title 5, United States Code, that govern ap-*  
6           *pointments in the competitive service, and without re-*  
7           *gard to the provisions of chapter 51, and subchapter*  
8           *III of chapter 53, of such title that relate to classifica-*  
9           *tion and pay rates under the General Schedule.*

10           “(2) *MEMBERSHIP.*—*The members of any peer*  
11           *review group established under this section shall be*  
12           *appointed from among individuals who by virtue of*  
13           *their training or experience are eminently qualified*  
14           *to carry out the duties of such peer review group. Of-*  
15           *icers and employees of the United States may not*  
16           *constitute more than 25 percent of the membership of*  
17           *any such group. Such officers and employees may not*  
18           *receive compensation for service on such groups in ad-*  
19           *dition to the compensation otherwise received for these*  
20           *duties carried out as such officers and employees.*

21           “(3) *DURATION.*—*Notwithstanding section 14(a)*  
22           *of the Federal Advisory Committee Act, peer review*  
23           *groups established under this section may continue in*  
24           *existence until otherwise provided by law.*

1           “(4) *QUALIFICATIONS.*—*Members of any peer-re-*  
2           *view group shall, at a minimum, meet the following*  
3           *requirements:*

4                   “(A) *Such members shall agree in writing*  
5                   *to treat information received, pursuant to their*  
6                   *work for the group, as confidential information,*  
7                   *except that this subparagraph shall not apply to*  
8                   *public records and public information.*

9                   “(B) *Such members shall agree in writing*  
10                  *to recuse themselves from participation in the*  
11                  *peer-review of specific applications which present*  
12                  *a potential personal conflict of interest or ap-*  
13                  *pearance of such conflict, including employment*  
14                  *in a directly affected organization, stock owner-*  
15                  *ship, or any financial or other arrangement that*  
16                  *might introduce bias in the process of peer-re-*  
17                  *view.*

18           “(d) *AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN*  
19           *CERTAIN CASES.*—*In the case of applications for financial*  
20           *assistance whose direct costs will not exceed \$100,000, the*  
21           *Director may make appropriate adjustments in the proce-*  
22           *dures otherwise established by the Director for the conduct*  
23           *of peer review under this section. Such adjustments may*  
24           *be made for the purpose of encouraging the entry of individ-*  
25           *uals into the field of research, for the purpose of encour-*

1 *aging clinical practice-oriented or provider-based research,*  
 2 *and for such other purposes as the Director may determine*  
 3 *to be appropriate.*

4 “(e) *REGULATIONS.—The Director shall issue regula-*  
 5 *tions for the conduct of peer review under this section.*

6 **“SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVEL-**  
 7 **OPMENT, COLLECTION, AND DISSEMINATION**  
 8 **OF DATA.**

9 “(a) *STANDARDS WITH RESPECT TO UTILITY OF*  
 10 *DATA.—*

11 “(1) *IN GENERAL.—To ensure the utility, accu-*  
 12 *racy, and sufficiency of data collected by or for the*  
 13 *Agency for the purpose described in section 901(b),*  
 14 *the Director shall establish standard methods for de-*  
 15 *veloping and collecting such data, taking into*  
 16 *consideration—*

17 “(A) *other Federal health data collection*  
 18 *standards; and*

19 “(B) *the differences between types of*  
 20 *healthcare plans, delivery systems, healthcare*  
 21 *providers, and provider arrangements.*

22 “(2) *RELATIONSHIP WITH OTHER DEPARTMENT*  
 23 *PROGRAMS.—In any case where standards under*  
 24 *paragraph (1) may affect the administration of other*  
 25 *programs carried out by the Department of Health*

1        *and Human Services, including the programs under*  
2        *title XVIII, XIX or XXI of the Social Security Act,*  
3        *or may affect health information that is subject to a*  
4        *standard developed under part C of title XI of the So-*  
5        *cial Security Act, they shall be in the form of rec-*  
6        *ommendations to the Secretary for such program.*

7        “(b) *STATISTICS AND ANALYSES.—The Director*  
8        *shall—*

9                “(1) *take appropriate action to ensure that sta-*  
10        *tistics and analyses developed under this title are of*  
11        *high quality, timely, and duly comprehensive, and*  
12        *that the statistics are specific, standardized, and ade-*  
13        *quately analyzed and indexed; and*

14                “(2) *publish, make available, and disseminate*  
15        *such statistics and analyses on as wide a basis as is*  
16        *practicable.*

17        “(c) *AUTHORITY REGARDING CERTAIN REQUESTS.—*  
18        *Upon request of a public or private entity, the Director may*  
19        *conduct or support research or analyses otherwise author-*  
20        *ized by this title pursuant to arrangements under which*  
21        *such entity will pay the cost of the services provided.*  
22        *Amounts received by the Director under such arrangements*  
23        *shall be available to the Director for obligation until ex-*  
24        *pended.*

1 **“SEC. 924. DISSEMINATION OF INFORMATION.**

2 “(a) *IN GENERAL.*—*The Director shall—*

3 “(1) *without regard to section 501 of title 44,*  
4 *United States Code, promptly publish, make avail-*  
5 *able, and otherwise disseminate, in a form under-*  
6 *standable and on as broad a basis as practicable so*  
7 *as to maximize its use, the results of research, dem-*  
8 *onstration projects, and evaluations conducted or sup-*  
9 *ported under this title;*

10 “(2) *ensure that information disseminated by the*  
11 *Agency is science-based and objective and undertakes*  
12 *consultation as necessary to assess the appropriate-*  
13 *ness and usefulness of the presentation of information*  
14 *that is targeted to specific audiences;*

15 “(3) *promptly make available to the public data*  
16 *developed in such research, demonstration projects,*  
17 *and evaluations;*

18 “(4) *provide, in collaboration with the National*  
19 *Library of Medicine where appropriate, indexing, ab-*  
20 *stracting, translating, publishing, and other services*  
21 *leading to a more effective and timely dissemination*  
22 *of information on research, demonstration projects,*  
23 *and evaluations with respect to healthcare to public*  
24 *and private entities and individuals engaged in the*  
25 *improvement of healthcare delivery and the general*  
26 *public, and undertake programs to develop new or*

1        *improved methods for making such information avail-*  
2        *able; and*

3                *“(5) as appropriate, provide technical assistance*  
4        *to State and local government and health agencies*  
5        *and conduct liaison activities to such agencies to fos-*  
6        *ter dissemination.*

7        *“(b) PROHIBITION AGAINST RESTRICTIONS.—Except*  
8        *as provided in subsection (c), the Director may not restrict*  
9        *the publication or dissemination of data from, or the results*  
10       *of, projects conducted or supported under this title.*

11       *“(c) LIMITATION ON USE OF CERTAIN INFORMA-*  
12       *TION.—No information, if an establishment or person sup-*  
13       *plying the information or described in it is identifiable, ob-*  
14       *tained in the course of activities undertaken or supported*  
15       *under this title may be used for any purpose other than*  
16       *the purpose for which it was supplied unless such establish-*  
17       *ment or person has consented (as determined under regula-*  
18       *tions of the Director) to its use for such other purpose. Such*  
19       *information may not be published or released in other form*  
20       *if the person who supplied the information or who is de-*  
21       *scribed in it is identifiable unless such person has consented*  
22       *(as determined under regulations of the Director) to its pub-*  
23       *lication or release in other form.*

24       *“(d) PENALTY.—Any person who violates subsection*  
25       *(c) shall be subject to a civil monetary penalty of not more*



1 *than \$10,000 for each such violation involved. Such penalty*  
 2 *shall be imposed and collected in the same manner as civil*  
 3 *money penalties under subsection (a) of section 1128A of*  
 4 *the Social Security Act are imposed and collected.*

5 **“SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO**  
 6 **GRANTS AND CONTRACTS.**

7 *“(a) FINANCIAL CONFLICTS OF INTEREST.—With re-*  
 8 *spect to projects for which awards of grants, cooperative*  
 9 *agreements, or contracts are authorized to be made under*  
 10 *this title, the Director shall by regulation define—*

11 *“(1) the specific circumstances that constitute fi-*  
 12 *nancial interests in such projects that will, or may be*  
 13 *reasonably expected to, create a bias in favor of ob-*  
 14 *taining results in the projects that are consistent with*  
 15 *such interests; and*

16 *“(2) the actions that will be taken by the Direc-*  
 17 *tor in response to any such interests identified by the*  
 18 *Director.*

19 *“(b) REQUIREMENT OF APPLICATION.—The Director*  
 20 *may not, with respect to any program under this title au-*  
 21 *thorizing the provision of grants, cooperative agreements,*  
 22 *or contracts, provide any such financial assistance unless*  
 23 *an application for the assistance is submitted to the Sec-*  
 24 *retary and the application is in such form, is made in such*  
 25 *manner, and contains such agreements, assurances, and in-*

1 *formation as the Director determines to be necessary to*  
2 *carry out the program in involved.*

3       “(c) *PROVISION OF SUPPLIES AND SERVICES IN LIEU*  
4 *OF FUNDS.—*

5               “(1) *IN GENERAL.—Upon the request of an enti-*  
6 *ty receiving a grant, cooperative agreement, or con-*  
7 *tract under this title, the Secretary may, subject to*  
8 *paragraph (2), provide supplies, equipment, and serv-*  
9 *ices for the purpose of aiding the entity in carrying*  
10 *out the project involved and, for such purpose, may*  
11 *detail to the entity any officer or employee of the De-*  
12 *partment of Health and Human Services.*

13               “(2) *CORRESPONDING REDUCTION IN FUNDS.—*  
14 *With respect to a request described in paragraph (1),*  
15 *the Secretary shall reduce the amount of the financial*  
16 *assistance involved by an amount equal to the costs*  
17 *of detailing personnel and the fair market value of*  
18 *any supplies, equipment, or services provided by the*  
19 *Director. The Secretary shall, for the payment of ex-*  
20 *penses incurred in complying with such request, ex-*  
21 *pend the amounts withheld.*

22       “(d) *APPLICABILITY OF CERTAIN PROVISIONS WITH*  
23 *RESPECT TO CONTRACTS.—Contracts may be entered into*  
24 *under this part without regard to sections 3648 and 3709*  
25 *of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).*

1   **“SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.**

2       “(a) *DEPUTY DIRECTOR AND OTHER OFFICERS AND*  
3   *EMPLOYEES.*—

4           “(1) *DEPUTY DIRECTOR.*—*The Director may ap-*  
5       *point a deputy director for the Agency.*

6           “(2) *OTHER OFFICERS AND EMPLOYEES.*—*The*  
7       *Director may appoint and fix the compensation of*  
8       *such officers and employees as may be necessary to*  
9       *carry out this title. Except as otherwise provided by*  
10       *law, such officers and employees shall be appointed in*  
11       *accordance with the civil service laws and their com-*  
12       *penetration fixed in accordance with title 5, United*  
13       *States Code.*

14       “(b) *FACILITIES.*—*The Secretary, in carrying out this*  
15   *title—*

16           “(1) *may acquire, without regard to the Act of*  
17       *March 3, 1877 (40 U.S.C. 34), by lease or otherwise*  
18       *through the Director of General Services, buildings or*  
19       *portions of buildings in the District of Columbia or*  
20       *communities located adjacent to the District of Co-*  
21       *lumbia for use for a period not to exceed 10 years;*  
22       *and*

23           “(2) *may acquire, construct, improve, repair, op-*  
24       *erate, and maintain laboratory, research, and other*  
25       *necessary facilities and equipment, and such other*

1       *real or personal property (including patents) as the*  
2       *Secretary deems necessary.*

3       “(c) *PROVISION OF FINANCIAL ASSISTANCE.—The Di-*  
4       *rector, in carrying out this title, may make grants to public*  
5       *and nonprofit entities and individuals, and may enter into*  
6       *cooperative agreements or contracts with public and private*  
7       *entities and individuals.*

8       “(d) *UTILIZATION OF CERTAIN PERSONNEL AND RE-*  
9       *SOURCES.—*

10           “(1) *DEPARTMENT OF HEALTH AND HUMAN*  
11       *SERVICES.—The Director, in carrying out this title,*  
12       *may utilize personnel and equipment, facilities, and*  
13       *other physical resources of the Department of Health*  
14       *and Human Services, permit appropriate (as deter-*  
15       *mined by the Secretary) entities and individuals to*  
16       *utilize the physical resources of such Department, and*  
17       *provide technical assistance and advice.*

18           “(2) *OTHER AGENCIES.—The Director, in car-*  
19       *rying out this title, may use, with their consent, the*  
20       *services, equipment, personnel, information, and fa-*  
21       *cilities of other Federal, State, or local public agen-*  
22       *cies, or of any foreign government, with or without*  
23       *reimbursement of such agencies.*

24       “(e) *CONSULTANTS.—The Secretary, in carrying out*  
25       *this title, may secure, from time to time and for such peri-*

1 *ods as the Director deems advisable but in accordance with*  
2 *section 3109 of title 5, United States Code, the assistance*  
3 *and advice of consultants from the United States or abroad.*

4 “(f) *EXPERTS.*—

5 “(1) *IN GENERAL.*—*The Secretary may, in car-*  
6 *rying out this title, obtain the services of not more*  
7 *than 50 experts or consultants who have appropriate*  
8 *scientific or professional qualifications. Such experts*  
9 *or consultants shall be obtained in accordance with*  
10 *section 3109 of title 5, United States Code, except that*  
11 *the limitation in such section on the duration of serv-*  
12 *ice shall not apply.*

13 “(2) *TRAVEL EXPENSES.*—

14 “(A) *IN GENERAL.*—*Experts and consult-*  
15 *ants whose services are obtained under para-*  
16 *graph (1) shall be paid or reimbursed for their*  
17 *expenses associated with traveling to and from*  
18 *their assignment location in accordance with sec-*  
19 *tions 5724, 5724a(a), 5724a(c), and 5726(C) of*  
20 *title 5, United States Code.*

21 “(B) *LIMITATION.*—*Expenses specified in*  
22 *subparagraph (A) may not be allowed in connec-*  
23 *tion with the assignment of an expert or consult-*  
24 *ant whose services are obtained under paragraph*  
25 *(1) unless and until the expert agrees in writing*

1           *to complete the entire period of assignment, or 1*  
2           *year, whichever is shorter, unless separated or re-*  
3           *assigned for reasons that are beyond the control*  
4           *of the expert or consultant and that are accept-*  
5           *able to the Secretary. If the expert or consultant*  
6           *violates the agreement, the money spent by the*  
7           *United States for the expenses specified in sub-*  
8           *paragraph (A) is recoverable from the expert or*  
9           *consultant as a statutory obligation owed to the*  
10          *United States. The Secretary may waive in*  
11          *whole or in part a right of recovery under this*  
12          *subparagraph.*

13          “(g) *VOLUNTARY AND UNCOMPENSATED SERVICES.—*  
14          *The Director, in carrying out this title, may accept vol-*  
15          *untary and uncompensated services.*

16          **“SEC. 927. FUNDING.**

17          “(a) *INTENT.—To ensure that the United States’s in-*  
18          *vestment in biomedical research is rapidly translated into*  
19          *improvements in the quality of patient care, there must be*  
20          *a corresponding investment in research on the most effective*  
21          *clinical and organizational strategies for use of these find-*  
22          *ings in daily practice. The authorization levels in sub-*  
23          *section (b) provide for a proportionate increase in*  
24          *healthcare research as the United States investment in bio-*  
25          *medical research increases.*

1       “(b) *AUTHORIZATION OF APPROPRIATIONS.*—For the  
 2   purpose of carrying out this title, there are authorized to  
 3   be appropriated \$250,000,000 for fiscal year 2000, and such  
 4   sums as may be necessary for each of the fiscal years 2001  
 5   through 2006.

6       “(c) *EVALUATIONS.*—In addition to amounts available  
 7   pursuant to subsection (b) for carrying out this title, there  
 8   shall be made available for such purpose, from the amounts  
 9   made available pursuant to section 241 (relating to evalua-  
 10   tions), an amount equal to 40 percent of the maximum  
 11   amount authorized in such section 241 to be made available  
 12   for a fiscal year.

13   **“SEC. 928. DEFINITIONS.**

14       *“In this title:*

15           “(1) *ADVISORY COUNCIL.*—The term ‘Advisory  
 16   Council’ means the Advisory Council on Healthcare  
 17   Research and Quality established under section 921.

18           “(2) *AGENCY.*—The term ‘Agency’ means the  
 19   Agency for Healthcare Research and Quality.

20           “(3) *DIRECTOR.*—The term ‘Director’ means the  
 21   Director for the Agency for Healthcare Research and  
 22   Quality.”.

23   **SEC. 403. REFERENCES.**

24       *Effective upon the date of enactment of this Act, any*  
 25   *reference in law to the “Agency for Health Care Policy and*

1 *Research” shall be deemed to be a reference to the “Agency*  
 2 *for Healthcare Research and Quality”.*

3 ***TITLE V—ENHANCED ACCESS TO***  
 4 ***HEALTH INSURANCE COVERAGE***

5 ***SEC. 501. FULL DEDUCTION OF HEALTH INSURANCE COSTS***  
 6 ***FOR SELF-EMPLOYED INDIVIDUALS.***

7 *(a) IN GENERAL.—Section 162(l)(1) of the Internal*  
 8 *Revenue Code of 1986 (relating to allowance of deductions)*  
 9 *is amended to read as follows:*

10 *“(1) ALLOWANCE OF DEDUCTION.—In the case of*  
 11 *an individual who is an employee within the mean-*  
 12 *ing of section 401(c)(1), there shall be allowed as a*  
 13 *deduction under this section an amount equal to the*  
 14 *amount paid during the taxable year for insurance*  
 15 *which constitutes medical care for the taxpayer, his*  
 16 *spouse, and his dependents.”.*

17 *(b) EFFECTIVE DATE.—The amendments made by this*  
 18 *section shall apply to taxable years beginning after Decem-*  
 19 *ber 31, 1999.*

20 ***SEC. 502. FULL AVAILABILITY OF MEDICAL SAVINGS AC-***  
 21 ***COUNTS.***

22 *(a) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR*  
 23 *EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED*  
 24 *INDIVIDUALS.—*



1           (1) *IN GENERAL.*—Section 220(c)(1)(A) of the  
2           *Internal Revenue Code of 1986 (relating to eligible in-*  
3           *dividual) is amended to read as follows:*

4                     “(A) *IN GENERAL.*—The term ‘eligible indi-  
5                     vidual’ means, with respect to any month, any  
6                     individual if—

7                             “(i) such individual is covered under a  
8                             high deductible health plan as of the 1st day  
9                             of such month, and

10                            “(ii) such individual is not, while cov-  
11                            ered under a high deductible health plan,  
12                            covered under any health plan—

13                               “(I) which is not a high deduct-  
14                               ible health plan, and

15                               “(II) which provides coverage for  
16                               any benefit which is covered under the  
17                               high deductible health plan.”.

18           (2) *CONFORMING AMENDMENTS.*—

19                     (A) Section 220(c)(1) of such Code is  
20                     amended by striking subparagraphs (C) and (D).

21                     (B) Section 220(c) of such Code is amended  
22                     by striking paragraph (4) (defining small em-  
23                     ployer) and by redesignating paragraph (5) as  
24                     paragraph (4).

1           (C) *Section 220(b) of such Code is amended*  
 2           *by striking paragraph (4) (relating to deduction*  
 3           *limited by compensation) and by redesignating*  
 4           *paragraphs (5), (6), and (7) as paragraphs (4),*  
 5           *(5), and (6), respectively.*

6           (b) *REMOVAL OF LIMITATION ON NUMBER OF TAX-*  
 7           *PAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—*

8           (1) *IN GENERAL.—Section 220 of the Internal*  
 9           *Revenue Code of 1986 (relating to medical savings ac-*  
 10           *counts) is amended by striking subsections (i) and (j).*

11           (2) *MEDICARE+CHOICE.—Section 138 of such*  
 12           *Code (relating to Medicare+Choice MSA) is amended*  
 13           *by striking subsection (f).*

14           (c) *REDUCTION IN HIGH DEDUCTIBLE PLAN MINIMUM*  
 15           *ANNUAL DEDUCTIBLE.—*

16           (1) *IN GENERAL.—Subparagraph (A) of section*  
 17           *220(c)(2) of such Code (defining high deductible*  
 18           *health plan) is amended—*

19                   (A) *by striking “\$1,500” and inserting*  
 20                   *“\$1,000”, and*

21                   (B) *by striking “\$3,000” in clause (ii) and*  
 22                   *inserting “\$2,000”.*

23           (2) *CONFORMING AMENDMENT.—Subsection (g)*  
 24           *of section 220 of such Code is amended—*

1                   (A) by striking “1998” and inserting  
2                   “1999”; and

3                   (B) by striking “1997” and inserting  
4                   “1998”.

5           (d) *INCREASE IN CONTRIBUTION LIMIT TO 100 PER-*  
6 *CENT OF ANNUAL DEDUCTIBLE.*—

7                   (1) *IN GENERAL.*—Section 220(b)(2) of the *Inter-*  
8 *nal Revenue Code of 1986 (relating to monthly limi-*  
9 *tation) is amended to read as follows:*

10                   “(2) *MONTHLY LIMITATION.*—The monthly limi-  
11 *tation for any month is the amount equal to  $\frac{1}{12}$  of*  
12 *the annual deductible of the high deductible health*  
13 *plan of the individual.”.*

14                   (2) *CONFORMING AMENDMENT.*—Section  
15 *220(d)(1)(A) of such Code is amended by striking “75*  
16 *percent of”.*

17           (e) *LIMITATION ON ADDITIONAL TAX ON DISTRIBUTI-*  
18 *ONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.*—  
19 *Section 220(f)(4) of the Internal Revenue Code of 1986 (re-*  
20 *lating to additional tax on distributions not used for quali-*  
21 *fied medical expenses) is amended by adding at the end the*  
22 *following:*

23                   “(D) *EXCEPTION IN CASE OF SUFFICIENT*  
24 *ACCOUNT BALANCE.*—Subparagraph (A) shall  
25 *not apply to any payment or distribution in*

any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible health plan of the account holder (determined as of January 1 of the calendar year in which the taxable year begins).”.

(f) *TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.*—Section 220(c)(2)(B) of the Internal Revenue Code of 1986 (relating to special rules for high deductible health plans) is amended by adding at the end the following:

“(iii) *TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.*—A plan that provides health care services through a network of contracted or affiliated health care providers, if the benefits provided when services are obtained through network providers meet the requirements of subparagraph (A), shall not fail to be treated as a high deductible health plan by reason of providing benefits for services rendered by providers who are not members of the network, so long as the annual deductible and annual limit on out-of-pocket expenses applicable to services

1                   received from non-network providers are not  
 2                   lower than those applicable to services re-  
 3                   ceived from the network providers.”.

4           (g) *EFFECTIVE DATE.*—The amendments made by this  
 5 section shall apply to taxable years beginning after Decem-  
 6 ber 31, 1999.

7   **SEC. 503. PERMITTING CONTRIBUTION TOWARDS MEDICAL**  
 8                   **SAVINGS ACCOUNT THROUGH FEDERAL EM-**  
 9                   **PLOYEES HEALTH BENEFITS PROGRAM**  
 10                   **(FEHBP).**

11           (a) *AUTHORITY TO CONTRACT FOR CATASTROPHIC*  
 12 *PLANS.*—Section 8902 of title 5, United States Code, is  
 13 amended by adding at the end the following:

14           “(p)(1) The Office shall contract under this chapter for  
 15 a catastrophic plan with any qualified carrier that—

16                   “(A) offers such a plan; and

17                   “(B) as of the date of enactment of the Patients’  
 18 Bill of Rights Plus Act, offers a health benefits plan  
 19 under this chapter.

20           “(2) The Office may contract under this chapter for  
 21 a catastrophic plan with any qualified carrier that—

22                   “(A) offers such a plan; but

23                   “(B) does not satisfy the requirement under  
 24 paragraph (1)(B).”.

1       (b) *GOVERNMENT CONTRIBUTION TO MEDICAL SAV-*  
2 *INGS ACCOUNT.*—

3           (1) *IN GENERAL.*—Section 8906 of title 5,  
4       *United States Code*, is amended by adding at the end  
5       *the following:*

6       “(j)(1) *In the case of an employee or annuitant who*  
7 *is enrolled in a catastrophic plan described by section*  
8 *8903(5), there shall be a Government contribution under*  
9 *this subsection to a medical savings account established or*  
10 *maintained for the benefit of the individual. The contribu-*  
11 *tion under this subsection shall be in addition to the Gov-*  
12 *ernment contribution under subsection (b).*

13       “(2) *The amount of the Government contribution*  
14 *under this subsection with respect to an individual is equal*  
15 *to the amount by which—*

16           “(A) *the maximum contribution allowed under*  
17 *subsection (b)(1) with respect to any employee or an-*  
18 *nuitant, exceeds*

19           “(B) *the amount of the Government contribution*  
20 *actually made with respect to the individual under*  
21 *subsection (b) for coverage under the catastrophic*  
22 *plan.*

23       “(3) *The Government contributions under this sub-*  
24 *section shall be paid into a medical savings account (des-*  
25 *ignated by the individual involved) in a manner that is*

1 *specified by the Office and consistent with the timing of*  
 2 *contributions under subsection (b).*

3       “(4) Subsections (f) and (g) shall apply to contribu-  
 4 *tions under this section in the same manner as they apply*  
 5 *to contributions under subsection (b).*

6       “(5) For the purpose of this subsection, the term ‘med-  
 7 *ical savings account*’ has the meaning given such term by  
 8 *section 220(d) of the Internal Revenue Code of 1986.*”.

9               (2) *ALLOWING PAYMENT OF FULL AMOUNT OF*  
 10 *CHARGE FOR CATASTROPHIC PLAN.*—Section  
 11 *8906(b)(2) of such title is amended by inserting “(or*  
 12 *100 percent of the subscription charge in the case of*  
 13 *a catastrophic plan)” after “75 percent of the sub-*  
 14 *scription charge”.*

15       (c) *OFFERING OF CATASTROPHIC PLANS.*—

16               (1) *IN GENERAL.*—Section 8903 of title 5,  
 17 *United States Code, is amended by adding at the end*  
 18 *the following:*

19               “(5) *CATASTROPHIC PLANS.*—(A) *One or more*  
 20 *plans described in paragraph (1), (2), or (3), but*  
 21 *which provide benefits of the types referred to by*  
 22 *paragraph (5) of section 8904(a), instead of the types*  
 23 *referred to in paragraphs (1), (2), and (3) of such sec-*  
 24 *tion.*

1           “(B) Nothing in this section shall be  
2       *considered—*

3           “(i) to prevent a carrier from simulta-  
4       *neously offering a plan described by subpara-*  
5       *graph (A) and a plan described by paragraph*  
6       *(1) or (2);*

7           “(ii) to require that a catastrophic plan  
8       *offer two levels of benefits; or*

9           “(iii) to allow, in any contract year, for—

10           “(I) more than one plan to be offered  
11       *which satisfies both subparagraph (A) and*  
12       *paragraph (1) (subject to clause (ii)); and*

13           “(II) more than one plan which satis-  
14       *fies both subparagraph (A) and paragraph*  
15       *(2) (subject to clause (ii)).”.*

16       (2) *TYPES OF BENEFITS.—Section 8904(a) of*  
17       *such title is amended by inserting after paragraph (4)*  
18       *the following new paragraph:*

19           “(5) *CATASTROPHIC PLANS.—Benefits of the*  
20       *types named under paragraph (1) or (2) of this sub-*  
21       *section or both, except that the plan shall meet the an-*  
22       *nuual deductible and annual out-of-pocket expenses re-*  
23       *quirements under section 220(c)(2) of the Internal*  
24       *Revenue Code of 1986.”.*



1           (3) *DETERMINING LEVEL OF GOVERNMENT CON-*  
 2           *TRIBUTIONS.*—Section 8906(b) of such title is amend-  
 3           *ed by adding at the end the following: “Subscription*  
 4           *charges for medical savings accounts shall be deemed*  
 5           *to be the amount of Government contributions made*  
 6           *under subsection (j)(2).”.*

7           (d) *CONFORMING AMENDMENTS.*—

8           (1) *ADDITIONAL HEALTH BENEFITS PLANS.*—  
 9           Section 8903a of title 5, United States Code, is  
 10          *amended by redesignating subsection (d) as subsection*  
 11          *(e) and by inserting after subsection (c) the following:*  
 12          *“(d) The plans under this section may include one or*  
 13          *more plans, otherwise allowable under this section, that sat-*  
 14          *isfy the requirements of clauses (i) and (ii) of section*  
 15          *8903(5)(A).”.*

16          (2) *REFERENCE.*—Section 8909(d) of title 5,  
 17          United States Code, is amended by striking  
 18          “8903a(d)” and inserting “8903a(e)”.

19          (e) *REFERENCES.*—Section 8903 of title 5, United  
 20          States Code, is amended by adding at the end (as a flush  
 21          left sentence) the following:

22          *“The Office shall prescribe regulations under which the re-*  
 23          *quirements of section 8902(c), 8902(n), 8909(e), and any*  
 24          *other provision of this chapter that applies with respect to*  
 25          *a plan described by paragraph (1), (2), (3), or (4) of this*

1 *section shall apply with respect to the corresponding plan*  
 2 *under paragraph (5) of this section. Similar regulations*  
 3 *shall be prescribed with respect to any plan under section*  
 4 *8903a(d).”.*

5 *(f) EFFECTIVE DATE.—The amendments made by this*  
 6 *section shall apply to contract terms beginning on or after*  
 7 *January 1, 2000.*

8 **SEC. 504. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING AR-**  
 9 **RANGEMENTS, AND HEALTH FLEXIBLE**  
 10 **SPENDING ACCOUNTS.**  
 11

12 *(a) IN GENERAL.—Section 125 of the Internal Revenue*  
 13 *Code of 1986 (relating to cafeteria plans) is amended by*  
 14 *redesignating subsections (h) and (i) as subsections (i) and*  
 15 *(j) and by inserting after subsection (g) the following new*  
 16 *subsection:*

17 *“(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENE-*  
 18 *FITS TO LATER TAXABLE YEARS.—*

19 *“(1) IN GENERAL.—For purposes of this title—*  
 20 *“(A) notwithstanding subsection (d)(2), a*  
 21 *plan or other arrangement shall not fail to be*  
 22 *treated as a cafeteria plan or flexible spending or*  
 23 *similar arrangement, and*

1           “(B) no amount shall be required to be in-  
2           cluded in gross income by reason of this section  
3           or any other provision of this chapter,  
4           solely because under such plan or other arrangement  
5           any nontaxable benefit which is unused as of the close  
6           of a taxable year may be carried forward to 1 or more  
7           succeeding taxable years.

8           “(2) *LIMITATION.*—Paragraph (1) shall not  
9           apply to amounts carried from a plan to the extent  
10          such amounts exceed \$500 (applied on an annual  
11          basis). For purposes of this paragraph, all plans and  
12          arrangements maintained by an employer or any re-  
13          lated person shall be treated as 1 plan.

14          “(3) *ALLOWANCE OF ROLLOVER.*—

15                 “(A) *IN GENERAL.*—In the case of any un-  
16                 used benefit described in paragraph (1) which  
17                 consists of amounts in a health flexible spending  
18                 account or dependent care flexible spending ac-  
19                 count, the plan or arrangement shall provide  
20                 that a participant may elect, in lieu of such car-  
21                 ryover, to have such amounts distributed to the  
22                 participant.

23                 “(B) *AMOUNTS NOT INCLUDED IN IN-*  
24                 *COME.*—Any distribution under subparagraph  
25                 (A) shall not be included in gross income to the

1       *extent that such amount is transferred in a*  
2       *trustee-to-trustee transfer, or is contributed with-*  
3       *in 60 days of the date of the distribution, to—*

4               “(i) a qualified cash or deferred ar-  
5               rangement described in section 401(k),

6               “(ii) a plan under which amounts are  
7               contributed by an individual’s employer for  
8               an annuity contract described in section  
9               403(b),

10              “(iii) an eligible deferred compensation  
11              plan described in section 457, or

12              “(iv) a medical savings account (with-  
13              in the meaning of section 220).

14       *Any amount rolled over under this subparagraph*  
15       *shall be treated as a rollover contribution for the*  
16       *taxable year from which the unused amount*  
17       *would otherwise be carried.*

18              “(C) *TREATMENT OF ROLLOVER.—Any*  
19              *amount rolled over under subparagraph (B)*  
20              *shall be treated as an eligible rollover under sec-*  
21              *tion 220, 401(k), 403(b), or 457, whichever is ap-*  
22              *plicable, and shall be taken into account in ap-*  
23              *plying any limitation (or participation require-*  
24              *ment) on employer or employee contributions*

1           *under such section or any other provision of this*  
2           *chapter for the taxable year of the rollover.*

3           “(4) *COST-OF-LIVING ADJUSTMENT.*—*In the case*  
4           *of any taxable year beginning in a calendar year*  
5           *after 1999, the \$500 amount under paragraph (2)*  
6           *shall be adjusted at the same time and in the same*  
7           *manner as under section 415(d)(2), except that the*  
8           *base period taken into account shall be the calendar*  
9           *quarter beginning October 1, 1998, and any increase*  
10          *which is not a multiple of \$50 shall be rounded to the*  
11          *next lowest multiple of \$50.*

12          “(5) *APPLICABILITY.*—*This subsection shall*  
13          *apply to taxable years beginning after December 31,*  
14          *1999.”.*

15          “(b) *EFFECTIVE DATE.*—*The amendments made by this*  
16          *section shall apply to taxable years beginning after Decem-*  
17          *ber 31, 1999.*

1 **TITLE VI—PROVISIONS RELAT-**  
 2 **ING TO LONG-TERM CARE IN-**  
 3 **SURANCE**

4 **SEC. 601. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**  
 5 **SURANCE CONTRACTS IN CAFETERIA PLANS,**  
 6 **FLEXIBLE SPENDING ARRANGEMENTS, AND**  
 7 **HEALTH FLEXIBLE SPENDING ACCOUNTS.**

8 (a) *IN GENERAL.*—Section 125(f) of the Internal Rev-  
 9 enue Code of 1986 (defining qualified benefits) is amended  
 10 by striking the last sentence and inserting the following:  
 11 “Such term includes any qualified long-term care insurance  
 12 contract.”.

13 (b) *EFFECTIVE DATE.*—The amendment made by this  
 14 section shall apply to taxable years beginning after Decem-  
 15 ber 31, 1999.

16 **SEC. 602. DEDUCTION FOR PREMIUMS FOR LONG-TERM**  
 17 **CARE INSURANCE.**

18 (a) *IN GENERAL.*—Part VII of subchapter B of chapter  
 19 1 of the Internal Revenue Code of 1986 (relating to addi-  
 20 tional itemized deductions) is amended by redesignating  
 21 section 222 as section 223 and by inserting after section  
 22 221 the following:

23 **“SEC. 222. PREMIUMS FOR LONG-TERM CARE INSURANCE.**

24 **“(a) IN GENERAL.**—In the case of an eligible indi-  
 25 vidual, there shall be allowed as a deduction an amount

1 *equal to 100 percent of the amount paid during the taxable*  
 2 *year for any coverage for qualified long-term care services*  
 3 *(as defined in section 7702B(c)) or any qualified long-term*  
 4 *care insurance contract (as defined in section 7702B(b))*  
 5 *which constitutes medical care for the taxpayer, his spouse,*  
 6 *and dependents.*

7 “(b) *LIMITATIONS.*—

8 “(1) *DEDUCTION NOT AVAILABLE TO INDIVID-*  
 9 *UALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COV-*  
 10 *ERAGE.*—

11 “(A) *IN GENERAL.*—*Except as provided in*  
 12 *subparagraph (B), subsection (a) shall not apply*  
 13 *to any taxpayer for any calendar month for*  
 14 *which the taxpayer is eligible to participate in*  
 15 *any plan which includes coverage for qualified*  
 16 *long-term care services (as so defined) or is a*  
 17 *qualified long-term care insurance contract (as*  
 18 *so defined) maintained by any employer (or*  
 19 *former employer) of the taxpayer or of the spouse*  
 20 *of the taxpayer.*

21 “(B) *CONTINUATION COVERAGE.*—*Coverage*  
 22 *shall not be treated as subsidized for purposes of*  
 23 *this paragraph if—*

24 “(i) *such coverage is continuation cov-*  
 25 *erage (within the meaning of section*

1           4980B(f)) required to be provided by the  
2           employer, and

3           “(ii) the taxpayer or the taxpayer’s  
4           spouse is required to pay a premium for  
5           such coverage in an amount not less than  
6           100 percent of the applicable premium  
7           (within the meaning of section 4980B(f)(4))  
8           for the period of such coverage.

9           “(2) *LIMITATION ON LONG-TERM CARE PRE-*  
10          *MIUMS.*—In the case of a qualified long-term care in-  
11          surance contract (as so defined), only eligible long-  
12          term care premiums (as defined in section  
13          213(d)(10)) shall be taken into account under sub-  
14          section (a)(2).

15          “(c) *SPECIAL RULES.*—For purposes of this section—

16               “(1) *COORDINATION WITH MEDICAL DEDUCTION,*  
17               *ETC.*—Any amount paid by a taxpayer for insurance  
18               to which subsection (a) applies shall not be taken into  
19               account in computing the amount allowable to the  
20               taxpayer as a deduction under section 213(a).

21               “(2) *DEDUCTION NOT ALLOWED FOR SELF-EM-*  
22               *PLOYMENT TAX PURPOSES.*—The deduction allowable  
23               by reason of this section shall not be taken into ac-  
24               count in determining an individual’s net earnings



1       *from self-employment (within the meaning of section*  
 2       *1402(a)) for purposes of chapter 2.”.*

3       **(b) CONFORMING AMENDMENTS.—**

4               *(1) Subsection (a) of section 62 of the Internal*  
 5       *Revenue Code of 1986 is amended by inserting after*  
 6       *paragraph (17) the following:*

7               *“(18) LONG-TERM CARE INSURANCE COSTS OF*  
 8       *CERTAIN INDIVIDUALS.—The deduction allowed by*  
 9       *section 222.”.*

10              *(2) The table of sections for part VII of sub-*  
 11       *chapter B of chapter 1 of such Code is amended by*  
 12       *striking the last item and inserting the following:*

*“Sec. 222. Premiums for long-term care insurance.*  
       *“Sec. 223. Cross reference.”.*

13              **(c) EFFECTIVE DATE.—***The amendments made by this*  
 14       *section shall apply to taxable years beginning after Decem-*  
 15       *ber 31, 1999.*

16       **SEC. 603. STUDY OF LONG-TERM CARE NEEDS IN THE 21ST**  
 17               **CENTURY.**

18              **(a) IN GENERAL.—***The Secretary of Health and*  
 19       *Human Services (referred to in this section as the “Sec-*  
 20       *retary”)* shall provide, in accordance with this section, for  
 21       *a study in order to determine—*

22              *(1) future demand for long-term health care serv-*  
 23       *ices (including institutional and home and commu-*

1       nity-based services) in the United States in order to  
2       meet the needs in the 21st century; and

3               (2) long-term options to finance the provision of  
4       such services.

5       (b) *DETAILS.*—The study conducted under subsection  
6 (a) shall include the following:

7               (1) An identification of the relevant demographic  
8       characteristics affecting demand for long-term health  
9       care services, at least through the year 2030.

10              (2) The viability and capacity of community-  
11       based and other long-term health care services under  
12       different federal programs, including through the  
13       medicare and medicaid programs, grants to States,  
14       housing services, and changes in tax policy.

15              (3) How to improve the quality of long-term  
16       health care services.

17              (4) The integration of long-term health care serv-  
18       ices for individuals between different classes of health  
19       care providers (such as hospitals, nursing facilities,  
20       and home care agencies) and different Federal pro-  
21       grams (such as the medicare and medicaid pro-  
22       grams).

23              (5) The possibility of expanding private sector  
24       initiatives, including long-term care insurance, to  
25       meet the need to finance such services.

1           (6) *An examination of the effect of enactment of*  
2           *the Health Insurance Portability and Accountability*  
3           *Act of 1996 on the provision and financing of long-*  
4           *term health care services, including on portability*  
5           *and affordability of private long-term care insurance,*  
6           *the impact of insurance options on low-income older*  
7           *Americans, and the options for eligibility to improve*  
8           *access to such insurance.*

9           (7) *The financial impact of the provision of*  
10          *long-term health care services on caregivers and other*  
11          *family members.*

12          (c) *REPORT AND RECOMMENDATIONS.—*

13           (1) *IN GENERAL.—Not later than 1 year after*  
14          *the date of the enactment of this Act, the Secretary*  
15          *shall provide for a report on the study under this sec-*  
16          *tion.*

17           (2) *RECOMMENDATIONS.—The report under*  
18          *paragraph (1) shall include findings and rec-*  
19          *ommendations regarding each of the following:*

20           (A) *The most effective and efficient manner*  
21          *that the Federal government may use its re-*  
22          *sources to educate the public on planning for*  
23          *needs for long-term health care services.*

1           (B) *The public, private, and joint public-*  
2           *private strategies for meeting identified needs for*  
3           *long-term health care services.*

4           (C) *The role of States and local commu-*  
5           *nities in the financing of long-term health care*  
6           *services.*

7           (3) *INCLUSION OF COST ESTIMATES.—The report*  
8           *under paragraph (1) shall include cost estimates of*  
9           *the various options for which recommendations are*  
10          *made.*

11          (d) *CONDUCT OF STUDY.—*

12           (1) *USE OF INSTITUTE OF MEDICINE.—The Sec-*  
13          *retary of Health and Human Services shall seek to*  
14          *enter into an appropriate arrangement with the In-*  
15          *stitute of Medicine of the National Academy of*  
16          *Sciences to conduct the study under this section. If*  
17          *such an arrangement cannot be made, the Secretary*  
18          *may provide for the conduct of the study by any other*  
19          *qualified non-governmental entity.*

20           (2) *CONSULTATION.—The study should be con-*  
21          *ducted under this section in consultation with experts*  
22          *from a wide-range of groups from the public and pri-*  
23          *vate sectors.*

**TITLE VII—INDIVIDUAL  
RETIREMENT PLANS**

**SEC. 701. MODIFICATION OF INCOME LIMITS ON CONTRIBUTIONS AND ROLLOVERS TO ROTH IRAS.**

*(a) INCREASE IN AGI LIMIT FOR ROLLOVER CONTRIBUTIONS.—Clause (i) of section 408A(c)(3)(A) of the Internal Revenue Code of 1986 (relating to rollover from IRA), as redesignated by subsection (a), is amended by striking “\$100,000” and inserting “\$1,000,000”.*

*(b) CONFORMING AMENDMENTS.—*

*(1)(A) Subparagraph (B) of section 408A(c)(3) of the Internal Revenue Code of 1986, as redesignated by subsection (a), is amended to read as follows:*

*“(B) DEFINITION OF ADJUSTED GROSS INCOME.—For purposes of subparagraph (A), adjusted gross income shall be determined—*

*“(i) after application of sections 86 and 469, and*

*“(ii) without regard to sections 135, 137, 221, and 911, the deduction allowable under section 219, or any amount included in gross income under subsection (d)(3).”.*

*(B) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 1999.*

1           (2)(A) Subparagraph (B) of section 408A(c)(3)  
 2       of such Code, as amended by paragraph (1), is  
 3       amended to read as follows:

4           “(B) DEFINITION OF ADJUSTED GROSS IN-  
 5       COME.—For purposes of subparagraph (A), ad-  
 6       justed gross income shall be determined—

7           “(i) after application of sections 86  
 8       and 469, and

9           “(ii) without regard to sections 135,  
 10       137, 221, and 911, the deduction allowable  
 11       under section 219, or any amount included  
 12       in gross income under subsection (d)(3) or  
 13       by reason of a required distribution under  
 14       a provision described in paragraph (5).”.

15       (B) EFFECTIVE DATE.—The amendment made  
 16       by this paragraph shall apply to taxable years begin-  
 17       ning after December 31, 2004.

18       (c) EFFECTIVE DATE.—Except as otherwise provided  
 19       in this section, the amendments made by this section shall  
 20       apply to taxable years beginning after December 31, 1999.

# **TITLE VIII—REVENUE PROVISIONS**

## **SEC. 801. MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.**

(a) *IN GENERAL.*—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(1) by striking “in the second preceding taxable year,” and

(2) by striking “or fifth” and inserting “fifth, sixth, or seventh”.

(b) *EFFECTIVE DATE.*—The amendment made by subsection (a) shall apply to credits arising in taxable years beginning after December 31, 2001.

## **SEC. 802. LIMITATION ON USE OF NON-ACCRUAL EXPERIENCE METHOD OF ACCOUNTING.**

(a) *IN GENERAL.*—Section 448(d)(5) of the Internal Revenue Code of 1986 (relating to special rule for services) is amended—

(1) by inserting “in fields described in paragraph (2)(A)” after “services by such person”, and

(2) by inserting “CERTAIN PERSONAL” before “SERVICES” in the heading.

(b) *EFFECTIVE DATE.*—

1           (1) *IN GENERAL.*—*The amendments made by*  
 2           *this section shall apply to taxable years ending after*  
 3           *the date of the enactment of this Act.*

4           (2) *CHANGE IN METHOD OF ACCOUNTING.*—*In*  
 5           *the case of any taxpayer required by the amendments*  
 6           *made by this section to change its method of account-*  
 7           *ing for its first taxable year ending after the date of*  
 8           *the enactment of this Act—*

9                     (A) *such change shall be treated as initiated*  
 10            *by the taxpayer,*

11                    (B) *such change shall be treated as made*  
 12            *with the consent of the Secretary of the Treasury,*  
 13            *and*

14                    (C) *the net amount of the adjustments re-*  
 15            *quired to be taken into account by the taxpayer*  
 16            *under section 481 of the Internal Revenue Code*  
 17            *of 1986 shall be taken into account over a period*  
 18            *(not greater than 4 taxable years) beginning*  
 19            *with such first taxable year.*

20 **SEC. 803. RETURNS RELATING TO CANCELLATIONS OF IN-**  
 21 **DEBTEDNESS BY ORGANIZATIONS LENDING**  
 22 **MONEY.**

23           (a) *IN GENERAL.*—*Paragraph (2) of section 6050P(c)*  
 24           *of the Internal Revenue Code of 1986 (relating to definitions*  
 25           *and special rules) is amended by striking “and” at the end*



1 of subparagraph (B), by striking the period at the end of  
 2 subparagraph (C) and inserting “, and”, and by inserting  
 3 after subparagraph (C) the following new subparagraph:

4 “(D) any organization a significant trade  
 5 or business of which is the lending of money.”.

6 (b) *EFFECTIVE DATE.*—The amendment made by sub-  
 7 section (a) shall apply to discharges of indebtedness after  
 8 December 31, 1999.

9 **SEC. 804. EXTENSION OF INTERNAL REVENUE SERVICE**  
 10 **USER FEES.**

11 (a) *IN GENERAL.*—Chapter 77 of the Internal Revenue  
 12 Code of 1986 (relating to miscellaneous provisions) is  
 13 amended by adding at the end the following new section:

14 **“SEC. 7527. INTERNAL REVENUE SERVICE USER FEES.**

15 “(a) *GENERAL RULE.*—The Secretary shall establish  
 16 a program requiring the payment of user fees for—

17 “(1) requests to the Internal Revenue Service for  
 18 ruling letters, opinion letters, and determination let-  
 19 ters, and

20 “(2) other similar requests.

21 “(b) *PROGRAM CRITERIA.*—

22 “(1) *IN GENERAL.*—The fees charged under the  
 23 program required by subsection (a)—

24 “(A) shall vary according to categories (or  
 25 subcategories) established by the Secretary,

1           “(B) shall be determined after taking into  
 2           account the average time for (and difficulty of)  
 3           complying with requests in each category (and  
 4           subcategory), and

5           “(C) shall be payable in advance.

6           “(2) *EXEMPTIONS, ETC.*—The Secretary shall  
 7           provide for such exemptions (and reduced fees) under  
 8           such program as the Secretary determines to be ap-  
 9           propriate.

10          “(3) *AVERAGE FEE REQUIREMENT.*—The average  
 11          fee charged under the program required by subsection  
 12          (a) shall not be less than the amount determined  
 13          under the following table:

<b>“Category</b>	<b>Average Fee</b>
<i>Employee plan ruling and opinion .....</i>	<i>\$250</i>
<i>Exempt organization ruling .....</i>	<i>\$350</i>
<i>Employee plan determination .....</i>	<i>\$300</i>
<i>Exempt organization determination .....</i>	<i>\$275</i>
<i>Chief counsel ruling .....</i>	<i>\$200.</i>

14          “(c) *TERMINATION.*—No fee shall be imposed under  
 15          this section with respect to requests made after September  
 16          30, 2009.”.

17          (b) *CONFORMING AMENDMENTS.*—

18                 (1) *The table of sections for chapter 77 of the In-*  
 19                 *ternal Revenue Code of 1986 is amended by adding*  
 20                 *at the end the following new item:*

“Sec. 7527. *Internal Revenue Service user fees.*”.

1           (2) *Section 10511 of the Revenue Act of 1987 is*  
 2       *repealed.*

3           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
 4       *section shall apply to requests made after the date of the*  
 5       *enactment of this Act.*

6       **SEC. 805. PROPERTY SUBJECT TO A LIABILITY TREATED IN**  
 7                       **SAME MANNER AS ASSUMPTION OF LIABIL-**  
 8                       **ITY.**

9           (a) *REPEAL OF PROPERTY SUBJECT TO A LIABILITY*  
 10       *TEST.*—

11           (1) *SECTION 357.*—*Section 357(a)(2) of the Inter-*  
 12       *nal Revenue Code of 1986 (relating to assumption of*  
 13       *liability) is amended by striking “, or acquires from*  
 14       *the taxpayer property subject to a liability”.*

15           (2) *SECTION 358.*—*Section 358(d)(1) of such*  
 16       *Code (relating to assumption of liability) is amended*  
 17       *by striking “or acquired from the taxpayer property*  
 18       *subject to a liability”.*

19           (3) *SECTION 368.*—

20           (A) *Section 368(a)(1)(C) of such Code is*  
 21       *amended by striking “, or the fact that property*  
 22       *acquired is subject to a liability,”.*

23           (B) *The last sentence of section*  
 24       *368(a)(2)(B) of such Code is amended by strik-*  
 25       *ing “, and the amount of any liability to which*

1           *any property acquired from the acquiring cor-*  
 2           *poration is subject,”.*

3           **(b) CLARIFICATION OF ASSUMPTION OF LIABILITY.—**

4           **(1) IN GENERAL.—***Section 357 of the Internal*  
 5           *Revenue Code of 1986 is amended by adding at the*  
 6           *end the following new subsection:*

7           **“(d) DETERMINATION OF AMOUNT OF LIABILITY AS-**  
 8           **SUMED.—**

9           **“(1) IN GENERAL.—***For purposes of this section,*  
 10           *section 358(d), section 362(d), section 368(a)(1)(C),*  
 11           *and section 368(a)(2)(B), except as provided in*  
 12           *regulations—*

13           **“(A) a recourse liability (or portion thereof)**  
 14           *shall be treated as having been assumed if, as de-*  
 15           *termined on the basis of all facts and cir-*  
 16           *cumstances, the transferee has agreed to, and is*  
 17           *expected to, satisfy such liability (or portion),*  
 18           *whether or not the transferor has been relieved of*  
 19           *such liability, and*

20           **“(B) except to the extent provided in para-**  
 21           *graph (2), a nonrecourse liability shall be treated*  
 22           *as having been assumed by the transferee of any*  
 23           *asset subject to such liability.*

24           **“(2) EXCEPTION FOR NONRECOURSE LIABIL-**  
 25           **ITY.—***The amount of the nonrecourse liability treated*

1       *as described in paragraph (1)(B) shall be reduced by*  
 2       *the lesser of—*

3               “(A) *the amount of such liability which an*  
 4               *owner of other assets not transferred to the trans-*  
 5               *feree and also subject to such liability has agreed*  
 6               *with the transferee to, and is expected to, satisfy,*  
 7               *or*

8               “(B) *the fair market value of such other as-*  
 9               *sets (determined without regard to section*  
 10              *7701(g)).*

11              “(3) *REGULATIONS.—The Secretary shall pre-*  
 12              *scribe such regulations as may be necessary to carry*  
 13              *out the purposes of this subsection and section 362(d).*  
 14              *The Secretary may also prescribe regulations which*  
 15              *provide that the manner in which a liability is treat-*  
 16              *ed as assumed under this subsection is applied, where*  
 17              *appropriate, elsewhere in this title.”.*

18              “(2) *LIMITATION ON BASIS INCREASE ATTRIB-*  
 19              *UTABLE TO ASSUMPTION OF LIABILITY.—Section 362*  
 20              *of such Code is amended by adding at the end the fol-*  
 21              *lowing new subsection:*

22              “(d) *LIMITATION ON BASIS INCREASE ATTRIBUTABLE*  
 23              *TO ASSUMPTION OF LIABILITY.—*

24              “(1) *IN GENERAL.—In no event shall the basis of*  
 25              *any property be increased under subsection (a) or (b)*

1     *above the fair market value of such property (deter-*  
 2     *mined without regard to section 7701(g)) by reason of*  
 3     *any gain recognized to the transferor as a result of*  
 4     *the assumption of a liability.*

5             “(2) *TREATMENT OF GAIN NOT SUBJECT TO*  
 6     *TAX.—Except as provided in regulations, if—*

7                 “(A) *gain is recognized to the transferor as*  
 8                 *a result of an assumption of a nonrecourse li-*  
 9                 *ability by a transferee which is also secured by*  
 10                *assets not transferred to such transferee, and*

11               “(B) *no person is subject to tax under this*  
 12                *title on such gain,*

13     *then, for purposes of determining basis under sub-*  
 14     *sections (a) and (b), the amount of gain recognized by*  
 15     *the transferor as a result of the assumption of the li-*  
 16     *ability shall be determined as if the liability assumed*  
 17     *by the transferee equaled such transferee’s ratable por-*  
 18     *tion of such liability determined on the basis of the*  
 19     *relative fair market values (determined without re-*  
 20     *gard to section 7701(g)) of all of the assets subject to*  
 21     *such liability.”.*

22     *(c) APPLICATION TO PROVISIONS OTHER THAN SUB-*  
 23     *CHAPTER C.—*

24             “(1) *SECTION 584.—Section 584(h)(3) of the Inter-*  
 25     *nal Revenue Code of 1986 is amended—*

1           (A) by striking “, and the fact that any  
 2           property transferred by the common trust fund is  
 3           subject to a liability,” in subparagraph (A), and  
 4           (B) by striking clause (ii) of subparagraph  
 5           (B) and inserting:

6                   “(ii) ASSUMED LIABILITIES.—For pur-  
 7                   poses of clause (i), the term ‘assumed liabil-  
 8                   ities’ means any liability of the common  
 9                   trust fund assumed by any regulated invest-  
 10                  ment company in connection with the  
 11                  transfer referred to in paragraph (1)(A).

12           “(C) ASSUMPTION.—For purposes of this  
 13           paragraph, in determining the amount of any li-  
 14           ability assumed, the rules of section 357(d) shall  
 15           apply.”.

16           (2) SECTION 1031.—The last sentence of section  
 17           1031(d) of such Code is amended—

18                   (A) by striking “assumed a liability of the  
 19                   taxpayer or acquired from the taxpayer property  
 20                   subject to a liability” and inserting “assumed  
 21                   (as determined under section 357(d)) a liability  
 22                   of the taxpayer”, and

23                   (B) by striking “or acquisition (in the  
 24                   amount of the liability)”.

25           (d) CONFORMING AMENDMENTS.—

1           (1) *Section 351(h)(1) of the Internal Revenue*  
 2           *Code of 1986 is amended by striking “, or acquires*  
 3           *property subject to a liability,”.*

4           (2) *Section 357 of such Code is amended by*  
 5           *striking “or acquisition” each place it appears in*  
 6           *subsection (a) or (b).*

7           (3) *Section 357(b)(1) of such Code is amended by*  
 8           *striking “or acquired”.*

9           (4) *Section 357(c)(1) of such Code is amended by*  
 10          *striking “, plus the amount of the liabilities to which*  
 11          *the property is subject,”.*

12          (5) *Section 357(c)(3) of such Code is amended by*  
 13          *striking “or to which the property transferred is sub-*  
 14          *ject”.*

15          (6) *Section 358(d)(1) of such Code is amended*  
 16          *by striking “or acquisition (in the amount of the li-*  
 17          *ability)”.*

18          (e) *EFFECTIVE DATE.*—*The amendments made by this*  
 19          *section shall apply to transfers after October 19, 1998.*

20          **SEC. 806. CHARITABLE SPLIT-DOLLAR LIFE INSURANCE, AN-**  
 21                                   **NUITY, AND ENDOWMENT CONTRACTS.**

22          (a) *IN GENERAL.*—*Subsection (f) of section 170 of the*  
 23          *Internal Revenue Code of 1986 (relating to disallowance of*  
 24          *deduction in certain cases and special rules) is amended*  
 25          *by adding at the end the following new paragraph:*



1           “(10) *SPLIT-DOLLAR LIFE INSURANCE, ANNUITY,*  
2           *AND ENDOWMENT CONTRACTS.*—

3           “(A) *IN GENERAL.*—*Nothing in this section*  
4           *or in section 545(b)(2), 556(b)(2), 642(c), 2055,*  
5           *2106(a)(2), or 2522 shall be construed to allow*  
6           *a deduction, and no deduction shall be allowed,*  
7           *for any transfer to or for the use of an organiza-*  
8           *tion described in subsection (c) if in connection*  
9           *with such transfer—*

10           “(i) *the organization directly or indi-*  
11           *rectly pays, or has previously paid, any*  
12           *premium on any personal benefit contract*  
13           *with respect to the transferor, or*

14           “(ii) *there is an understanding or ex-*  
15           *pectation that any person will directly or*  
16           *indirectly pay any premium on any per-*  
17           *sonal benefit contract with respect to the*  
18           *transferor.*

19           “(B) *PERSONAL BENEFIT CONTRACT.*—*For*  
20           *purposes of subparagraph (A), the term ‘personal*  
21           *benefit contract’ means, with respect to the*  
22           *transferor, any life insurance, annuity, or en-*  
23           *dowment contract if any direct or indirect bene-*  
24           *ficiary under such contract is the transferor, any*  
25           *member of the transferor’s family, or any other*

1        *person (other than an organization described in*  
2        *subsection (c)) designated by the transferor.*

3                *“(C) APPLICATION TO CHARITABLE REMAIN-*  
4        *DER TRUSTS.—In the case of a transfer to a*  
5        *trust referred to in subparagraph (E), references*  
6        *in subparagraphs (A) and (F) to an organiza-*  
7        *tion described in subsection (c) shall be treated*  
8        *as a reference to such trust.*

9                *“(D) EXCEPTION FOR CERTAIN ANNUITY*  
10       *CONTRACTS.—If, in connection with a transfer to*  
11       *or for the use of an organization described in*  
12       *subsection (c), such organization incurs an obli-*  
13       *gation to pay a charitable gift annuity (as de-*  
14       *finied in section 501(m)) and such organization*  
15       *purchases any annuity contract to fund such ob-*  
16       *ligation, persons receiving payments under the*  
17       *charitable gift annuity shall not be treated for*  
18       *purposes of subparagraph (B) as indirect bene-*  
19       *ficiaries under such contract if—*

20                    *“(i) such organization possesses all of*  
21                    *the incidents of ownership under such con-*  
22                    *tract,*

23                    *“(ii) such organization is entitled to*  
24                    *all the payments under such contract, and*

1           “(iii) *the timing and amount of pay-*  
 2           *ments under such contract are substantially*  
 3           *the same as the timing and amount of pay-*  
 4           *ments to each such person under such obli-*  
 5           *gation (as such obligation is in effect at the*  
 6           *time of such transfer).*

7           “(E) *EXCEPTION FOR CERTAIN CONTRACTS*  
 8           *HELD BY CHARITABLE REMAINDER TRUSTS.—A*  
 9           *person shall not be treated for purposes of sub-*  
 10           *paragraph (B) as an indirect beneficiary under*  
 11           *any life insurance, annuity, or endowment con-*  
 12           *tract held by a charitable remainder annuity*  
 13           *trust or a charitable remainder unitrust (as de-*  
 14           *finied in section 664(d)) solely by reason of being*  
 15           *entitled to any payment referred to in para-*  
 16           *graph (1)(A) or (2)(A) of section 664(d) if—*

17                   “(i) *such trust possesses all of the inci-*  
 18                   *dents of ownership under such contract, and*

19                   “(ii) *such trust is entitled to all the*  
 20                   *payments under such contract.*

21           “(F) *EXCISE TAX ON PREMIUMS PAID.—*

22                   “(i) *IN GENERAL.—There is hereby im-*  
 23                   *posed on any organization described in sub-*  
 24                   *section (c) an excise tax equal to the pre-*  
 25                   *miums paid by such organization on any*

1           *life insurance, annuity, or endowment con-*  
2           *tract if the payment of premiums on such*  
3           *contract is in connection with a transfer for*  
4           *which a deduction is not allowable under*  
5           *subparagraph (A), determined without re-*  
6           *gard to when such transfer is made.*

7           “(ii) *PAYMENTS BY OTHER PER-*  
8           *SONS.—For purposes of clause (i), pay-*  
9           *ments made by any other person pursuant*  
10           *to an understanding or expectation referred*  
11           *to in subparagraph (A) shall be treated as*  
12           *made by the organization.*

13           “(iii) *REPORTING.—Any organization*  
14           *on which tax is imposed by clause (i) with*  
15           *respect to any premium shall file an annual*  
16           *return which includes—*

17                   “(I) *the amount of such premiums*  
18                   *paid during the year and the name*  
19                   *and TIN of each beneficiary under the*  
20                   *contract to which the premium relates,*  
21                   *and*

22                   “(II) *such other information as*  
23                   *the Secretary may require.*

24           *The penalties applicable to returns required*  
25           *under section 6033 shall apply to returns*

1           *required under this clause. Returns required*  
2           *under this clause shall be furnished at such*  
3           *time and in such manner as the Secretary*  
4           *shall by forms or regulations require.*

5           “(iv) *CERTAIN RULES TO APPLY.—The*  
6           *tax imposed by this subparagraph shall be*  
7           *treated as imposed by chapter 42 for pur-*  
8           *poses of this title other than subchapter B*  
9           *of chapter 42.*

10          “(G) *SPECIAL RULE WHERE STATE RE-*  
11          *QUIRES SPECIFICATION OF CHARITABLE GIFT AN-*  
12          *NUITANT IN CONTRACT.—In the case of an obli-*  
13          *gation to pay a charitable gift annuity referred*  
14          *to in subparagraph (D) which is entered into*  
15          *under the laws of a State which requires, in*  
16          *order for the charitable gift annuity to be exempt*  
17          *from insurance regulation by such State, that*  
18          *each beneficiary under the charitable gift annu-*  
19          *ity be named as a beneficiary under an annuity*  
20          *contract issued by an insurance company au-*  
21          *thorized to transact business in such State, the*  
22          *requirements of clauses (i) and (ii) of subpara-*  
23          *graph (D) shall be treated as met if—*

24                “(i) *such State law requirement was in*  
25                *effect on February 8, 1999,*

1           “(ii) each such beneficiary under the  
 2           charitable gift annuity is a bona fide resi-  
 3           dent of such State at the time the obligation  
 4           to pay a charitable gift annuity is entered  
 5           into, and

6           “(iii) the only persons entitled to pay-  
 7           ments under such contract are persons enti-  
 8           tled to payments as beneficiaries under such  
 9           obligation on the date such obligation is en-  
 10          tered into.

11          “(H) REGULATIONS.—The Secretary shall  
 12          prescribe such regulations as may be necessary  
 13          or appropriate to carry out the purposes of this  
 14          paragraph, including regulations to prevent the  
 15          avoidance of such purposes.”.

16          (b) EFFECTIVE DATE.—

17               (1) IN GENERAL.—Except as otherwise provided  
 18               in this section, the amendment made by this section  
 19               shall apply to transfers made after February 8, 1999.

20               (2) EXCISE TAX.—Except as provided in para-  
 21               graph (3) of this subsection, section 170(f)(10)(F) of  
 22               the Internal Revenue Code of 1986 (as added by this  
 23               section) shall apply to premiums paid after the date  
 24               of the enactment of this Act.

1           (3) *REPORTING.*—Clause (iii) of such section  
 2       170(f)(10)(F) shall apply to premiums paid after  
 3       February 8, 1999 (determined as if the tax imposed  
 4       by such section applies to premiums paid after such  
 5       date).

6   **SEC. 807. TRANSFER OF EXCESS DEFINED BENEFIT PLAN**  
 7                   **ASSETS FOR RETIREE HEALTH BENEFITS.**

8       (a) *EXTENSION.*—

9           (1) *IN GENERAL.*—Section 420(b)(5) of the *Inter-*  
 10       *nal Revenue Code of 1986 (relating to expiration) is*  
 11       *amended by striking “in any taxable year beginning*  
 12       *after December 31, 2000” and inserting “made after*  
 13       *September 30, 2009”.*

14       (2) *CONFORMING AMENDMENTS.*—

15           (A) Section 101(e)(3) of the *Employee Re-*  
 16       *irement Income Security Act of 1974 (29 U.S.C.*  
 17       *1021(e)(3)) is amended by striking “1995” and*  
 18       *inserting “2001”.*

19           (B) Section 403(c)(1) of such Act (29 U.S.C.  
 20       1103(c)(1)) is amended by striking “1995” and in-  
 21       serting “2001”.

22           (C) Paragraph (13) of section 408(b) of such Act  
 23       (29 U.S.C. 1108(b)(13)) is amended—

(i) by striking “in a taxable year beginning before January 1, 2001” and inserting “made before October 1, 2009”, and

(ii) by striking “1995” and inserting “2001”.

(b) *APPLICATION OF MINIMUM COST REQUIREMENTS.—*

(1) *IN GENERAL.—Section 420(c)(3) of the Internal Revenue Code of 1986 is amended to read as follows:*

*“(3) MINIMUM COST REQUIREMENTS.—*

*“(A) IN GENERAL.—The requirements of this paragraph are met if each group health plan or arrangement under which applicable health benefits are provided provides that the applicable employer cost for each taxable year during the cost maintenance period shall not be less than the higher of the applicable employer costs for each of the 2 taxable years immediately preceding the taxable year of the qualified transfer.*

*“(B) APPLICABLE EMPLOYER COST.—For purposes of this paragraph, the term ‘applicable employer cost’ means, with respect to any taxable year, the amount determined by dividing—*



1           “(i) *the qualified current retiree health*  
2           *liabilities of the employer for such taxable*  
3           *year determined—*

4                     “(I) *without regard to any reduc-*  
5                     *tion under subsection (e)(1)(B), and*

6                     “(II) *in the case of a taxable year*  
7                     *in which there was no qualified trans-*  
8                     *fer, in the same manner as if there had*  
9                     *been such a transfer at the end of the*  
10                    *taxable year, by*

11                   “(ii) *the number of individuals to*  
12                   *whom coverage for applicable health benefits*  
13                   *was provided during such taxable year.*

14                   “(C) *ELECTION TO COMPUTE COST SEPA-*  
15                   *RATELY.—An employer may elect to have this*  
16                   *paragraph applied separately with respect to in-*  
17                   *dividuals eligible for benefits under title XVIII of*  
18                   *the Social Security Act at any time during the*  
19                   *taxable year and with respect to individuals not*  
20                   *so eligible.*

21                   “(D) *COST MAINTENANCE PERIOD.—For*  
22                   *purposes of this paragraph, the term ‘cost main-*  
23                   *tenance period’ means the period of 5 taxable*  
24                   *years beginning with the taxable year in which*  
25                   *the qualified transfer occurs. If a taxable year is*

in 2 or more overlapping cost maintenance periods, this paragraph shall be applied by taking into account the highest applicable employer cost required to be provided under subparagraph (A) for such taxable year.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 420(b)(1)(C)(iii) of such Code is amended by striking “benefits” and inserting “cost”.

(B) Section 420(e)(1)(D) of such Code is amended by striking “and shall not be subject to the minimum benefit requirements of subsection (c)(3)” and inserting “or in calculating applicable employer cost under subsection (c)(3)(B)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified transfers occurring after December 31, 2000, and before October 1, 2009.

**SEC. 808. LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.**

(a) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

“(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of

1           *a 10 or more employer plan if the only benefits*  
 2           *provided through the fund are 1 or more of the*  
 3           *following:*

4                     “(i) *Medical benefits.*

5                     “(ii) *Disability benefits.*

6                     “(iii) *Group term life insurance bene-*  
 7                     *fits which do not provide for any cash sur-*  
 8                     *render value or other money that can be*  
 9                     *paid, assigned, borrowed, or pledged for col-*  
 10                    *lateral for a loan.*

11           *The preceding sentence shall not apply to any*  
 12           *plan which maintains experience-rating arrange-*  
 13           *ments with respect to individual employers.”.*

14           **(b) LIMITATION ON USE OF AMOUNTS FOR OTHER**  
 15           **PURPOSES.**—*Section 4976(b) of the Internal Revenue Code*  
 16           *of 1986 (defining disqualified benefit) is amended by add-*  
 17           *ing at the end the following new paragraph:*

18                     **“(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER**  
 19                     **PLANS EXEMPTED FROM PREFUNDING LIMITS.**—*For*  
 20                     *purposes of paragraph (1)(C), if—*

21                     **“(A) subpart D of part I of subchapter D**  
 22                     *of chapter 1 does not apply by reason of section*  
 23                     *419A(f)(6) to contributions to provide 1 or more*  
 24                     *welfare benefits through a welfare benefit fund*  
 25                     *under a 10 or more employer plan, and*

1           “(B) any portion of the welfare benefit fund  
 2           attributable to such contributions is used for a  
 3           purpose other than that for which the contribu-  
 4           tions were made,  
 5           then such portion shall be treated as reverting to the  
 6           benefit of the employers maintaining the fund.”.

7           (c) *EFFECTIVE DATE.*—The amendments made by this  
 8           section shall apply to contributions paid or accrued after  
 9           the date of the enactment of this Act, in taxable years end-  
 10          ing after such date.

11   **SEC. 809. MODIFICATION OF INSTALLMENT METHOD AND**  
 12                   **REPEAL OF INSTALLMENT METHOD FOR AC-**  
 13                   **CRUAL METHOD TAXPAYERS.**

14           (a) *REPEAL OF INSTALLMENT METHOD FOR ACCRUAL*  
 15           *BASIS TAXPAYERS.*—

16                   (1) *IN GENERAL.*—Subsection (a) of section 453  
 17                   of the Internal Revenue Code of 1986 (relating to in-  
 18                   stallment method) is amended to read as follows:

19                   “(a) *USE OF INSTALLMENT METHOD.*—

20                           “(1) *IN GENERAL.*—Except as otherwise provided  
 21                           in this section, income from an installment sale shall  
 22                           be taken into account for purposes of this title under  
 23                           the installment method.

24                           “(2) *ACCRUAL METHOD TAXPAYER.*—The install-  
 25                           ment method shall not apply to income from an in-

1        *installment sale if such income would be reported under*  
 2        *an accrual method of accounting without regard to*  
 3        *this section. The preceding sentence shall not apply to*  
 4        *a disposition described in subparagraph (A) or (B) of*  
 5        *subsection (l)(2).”.*

6            (2)        *CONFORMING        AMENDMENTS.—Sections*  
 7        *453(d)(1), 453(i)(1), and 453(k) of such Code are each*  
 8        *amended by striking “(a)” each place it appears and*  
 9        *inserting “(a)(1)”.*

10        (b) *MODIFICATION OF PLEDGE RULES.—Paragraph*  
 11        *(4) of section 453A(d) of the Internal Revenue Code of 1986*  
 12        *(relating to pledges, etc., of installment obligations) is*  
 13        *amended by adding at the end the following: “A payment*  
 14        *shall be treated as directly secured by an interest in an*  
 15        *installment obligation to the extent an arrangement allows*  
 16        *the taxpayer to satisfy all or a portion of the indebtedness*  
 17        *with the installment obligation.”.*

18        (c) *EFFECTIVE DATE.—The amendments made by this*  
 19        *section shall apply to sales or other dispositions occurring*  
 20        *on or after the date of the enactment of this Act.*

1 **SEC. 810. INCLUSION OF CERTAIN VACCINES AGAINST**  
2 **STREPTOCOCCUS PNEUMONIAE TO LIST OF**  
3 **TAXABLE VACCINES.**

4 (a) *IN GENERAL.*—Section 4132(a)(1) of the Internal  
5 Revenue Code of 1986 (defining taxable vaccine) is amended  
6 by adding at the end the following new subparagraph:

7 “(L) Any conjugate vaccine against strepto-  
8 coccus pneumoniae.”.

9 (b) *EFFECTIVE DATE.*—

10 (1) *SALES.*—The amendment made by this sec-  
11 tion shall apply to vaccine sales beginning on the day  
12 after the date on which the Centers for Disease Con-  
13 trol makes a final recommendation for routine ad-  
14 ministration to children of any conjugate vaccine  
15 against streptococcus pneumoniae.

16 (2) *DELIVERIES.*—For purposes of paragraph  
17 (1), in the case of sales on or before the date described  
18 in such paragraph for which delivery is made after  
19 such date, the delivery date shall be considered the  
20 sale date.

**TITLE IX—MISCELLANEOUS  
PROVISIONS**

**SEC. 901. MEDICARE COMPETITIVE PRICING DEMONSTRATION PROJECT.**

*(a) FINDING.—The Senate finds that implementing competitive pricing in the medicare program under title XVIII of the Social Security Act is an important goal.*

*(b) PROHIBITION ON IMPLEMENTATION OF PROJECT IN CERTAIN AREAS.—Notwithstanding subsection (b) of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project (operated by the Secretary of Health and Human Services pursuant to such section) in Kansas City, Missouri or Kansas City, Kansas, or in any area in Arizona.*

*(c) MORATORIUM ON IMPLEMENTATION OF PROJECT IN ANY AREA UNTIL JANUARY, 1, 2001.—Notwithstanding any provision of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project in any area before January 1, 2001.*

*(d) STUDY AND REPORT TO CONGRESS.—*

1           (1) *STUDY.*—*The Secretary of Health and*  
2           *Human Services, in conjunction with the Competitive*  
3           *Pricing Advisory Committee, shall conduct a study on*  
4           *the different approaches of implementing the Medicare*  
5           *Competitive Pricing Demonstration Project on a vol-*  
6           *untary basis.*

7           (2) *REPORT.*—*Not later than June 30, 2000, the*  
8           *Secretary of Health and Human Services shall sub-*  
9           *mit a report to Congress which shall contain a de-*  
10          *tailed description of the study conducted under para-*  
11          *graph (1), together with the recommendations of the*  
12          *Secretary and the Competitive Pricing Advisory Com-*  
13          *mittee regarding the implementation of the Medicare*  
14          *Competitive Pricing Demonstration Project.*

Attest:

*Secretary.*



106TH CONGRESS  
1ST SESSION

**H. R. 2990**

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**AMENDMENT**

HR 2990 EAS—2

HR 2990 EAS—3

HR 2990 EAS—4

HR 2990 EAS—5

HR 2990 EAS—6

HR 2990 EAS—7

HR 2990 EAS—8

HR 2990 EAS—9

HR 2990 EAS—10

HR 2990 EAS—11

HR 2990 EAS—12

HR 2990 EAS—13

HR 2990 EAS—14

HR 2990 EAS—15

HR 2990 EAS—16

HR 2990 EAS—17

HR 2990 EAS—18

HR 2990 EAS—19

HR 2990 EAS—20